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JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION
VOL. 83, NO. 1 JANUARY 1987

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Legislative Roundup

The legislative year in review



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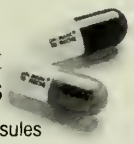
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References: **1.** Kales J, *et al: Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971. **2.** Kales A, *et al Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al. Clin Pharmacol Ther 32* 781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR. *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al. Behav Med*, pp 25-31, Oct 1978. **7.** Kales A, Kales JD. *J Clin Psychopharmacol 3* 140-150, Apr 1983. **8.** Tennant FS, *et al*: Symposium on the Treatment of Sleep Disorders, Telecanference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther 21* 355-361, Mar 1977

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FROM THE EDITOR

Editor's note: **This month's column has been written by the Chairman of the Journal Advisory Committee, Frederick H. Davidorf, M.D. Dr. Davidorf is Director of the Retina/Vitreous Service in the Department of Ophthalmology at The Ohio State University in Columbus.**

Over the past several years, the Editorial Board which oversees the content of the *Ohio State Medical Journal* has made an effort to improve the quality of the scientific material in the *Journal.* We adopted a strict peer review system for refereeing the articles submitted. If a majority of the committee feels the article is worthy of publication, it is published. A majority opinion is also necessary for rejection. Reviewers' comments on rejected articles are available to the author upon request. We seek articles which have broad interest to the physician in Ohio and we discourage publishing single case reports. However, high-quality clinical articles will continue to be accepted for peer review by the Board. In my opinion, the members of the Editorial Board: Craig G. Burkhart, M.D., Charles L. Heaton, M.D., William J. Marshall, M.D., and James F. Quilty, M.D., are quite conscientious about their commitment and I want to publicly thank them for their time and effort.

This year, the Board has made the major decision to change the name of the *Ohio State Medical Journal* to *Ohio Medicine.* There are several reasons for this decision. Because of the name, *The Ohio State Medical Journal* frequently has been erroneously considered a publication of The Ohio State University College of Medicine. The *Journal* is in reality the flagship publication of the Ohio State Medical Association and is published for the benefit of the membership throughout the state. We have felt for some time that the name should reflect this and so here we present the initial issue of *Ohio Medicine: the Journal of the Ohio State Medical Association.*

The new *Ohio Medicine,* as did the old *Ohio State Medical Journal,* will update the latest medical news and developments, both statewide and nationwide. *Ohio Medicine* will continue to include the latest socioeconomic trends.

Late this spring, *Ohio Medicine* will introduce an expanded clinical and scientific section which will focus on advances in medical subspecialties. Each section will consist of a brief introduction by that month's selected "Guest Editor," a review of the latest developments and a "Question-and-Answer" discussion.

We hope our expanded clinical section will meet the needs of those readers who would like to see more scientific material in the *Journal.* However, we are always open to suggestions, and would like to hear your thoughts on the matter. Please address your comments, either on the name change or the expanded clinical section to: "Letters to the Editor," Ohio Medicine, 600 S. High St., Columbus, Ohio 43215.

Frederick H. Davidorf, M.D.
Chairman
Journal Advisory Committee

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JOURNAL COVER:

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LETTERS TO THE EDITOR

In-flight medical kits: High costs for high risks

To the Editor:

I was very interested to read the article on In-flight Emergencies: Improving the Odds that appeared in the August 1986 issue of the *Ohio State Medical Journal.* The article points out that as of August 1, 1986 there will be a change in the type of emergency kit that is required for commercial airliners. The implication of the article is that both lives and money can be saved if there is a marked improvement in the type of equipment available on airlines. I submit there is absolutely no scientific basis for this type of thinking. Certainly the statistics regarding the cost savings and life-saving are arbitrary since they are based on the random selection of $650,000 of insurance monies.

Insurance aside, there is a clear implication that more equipment will equal lives saved. Having sat on committees that analyzed this problem relatively extensively, it is my feeling that the *only* piece of equipment which might save an occasional life in the air would be a defibrillator and, further, the difficulties in maintenance and the cost of carrying around the extra weight of the defibrillator would be very significant. Finally, I would submit that there would be enough potential for misuse of the defibrillator to totally negate its potential and rare effectiveness. It must be pointed out that even in the most ideal situations where pre-hospital CPR is rapidly available and is administered correctly and the patient is rapidly transported to a sophisticated and well-equipped emergency department, the "save" rate is dismally low. The addition of a few extra pieces of equipment — although perhaps rarely helpful — will certainly increase the cost of flying on an airliner for all of us.

High cost and complexity of health care delivery today mandates a rational and reasoned response from physicians who can balance both costs and benefits. I do not believe the article represents this type of reasoned approach.

Sincerely,
Bruce D. Janiak, MD, FACEP,
Director, Department of
Emergency Medicine
Toledo Hospital, Toledo

Correction

The December 1986 issue of The *Ohio State Medical Journal* mistakenly identified Joan Fulton, wife of the late Richard Fulton, MD, as Mrs. Jean Fulton in a photo caption which appeared on page 809. The Journal staff sincerely regrets the error.

Third Opinion: Hospital Medical Staff Section

To the Editor:

The article in the *OSMJ,* October, 1986, under Second Opinion, "Hospitals and county medical societies, should they be better bedfellows?" by Dr. George Griffin, strikes deeply, appropriately, and directly at the political machinations of medicine in the USA today. Dr. Griffin sounds the bell accurately as he points to the allegiance of the physicians to hospitals rather than to county medical societies, state organizations and the AMA. The hospital organization commands the attention of most physicians in this country today. The loyalty to the hospital medical staff is first.

Dr. Griffin has failed to study recent major changes in the direction of the American Medical Association. In June, 1982, the AMA directed that a new section of that august organization be developed called the Hospital Medical Staff Section. Its first meeting was at the annual meeting of the AMA in Chicago, June, 1983. The formation of this section was a stroke of perceptual genius in regards to the future of American medicine. It has shown that the directors of organized medicine had great insight into the practice of medicine in the USA to realize that the hospital medical staff is the real "backbone" for the future of American medicine.

The medical political framework of each hospital has become more important with each successive year. The reasons are numerous. The unity of the medical staff working directly with the hospital administration and indirectly with the Board of Trustees has solidified this grassroot working structure into an effective working machine. The unification of these "machines" throughout the country is the basis of the Hospital Medical Staff Section. This has had no precedent!

The hospital medical staff is represented at the state and national level. I invite Dr. Griffin to represent his hospital at the national meeting of the HMSS which is held twice a year. We invite each hospital to elect a physician as an official representative to both state and national meetings. The Ohio State Medical Association has its own HMSS section which meets in conjunction with the OSMA meeting in May. Its first meeting was held last year. We invite other interested physicians, administrators, hospital board members and lawyers to attend our conferences and speak to the issues of hospital medical staffs.

Indeed, this is a focused organization which is the ideal framework for Dr. Griffin's concerns. We welcome his views. I know that he and all hospital medical staffs will support the concept of this new section. We encourage all hospitals to join the hospital staff section of the OSMA. The representative

continued on page 60

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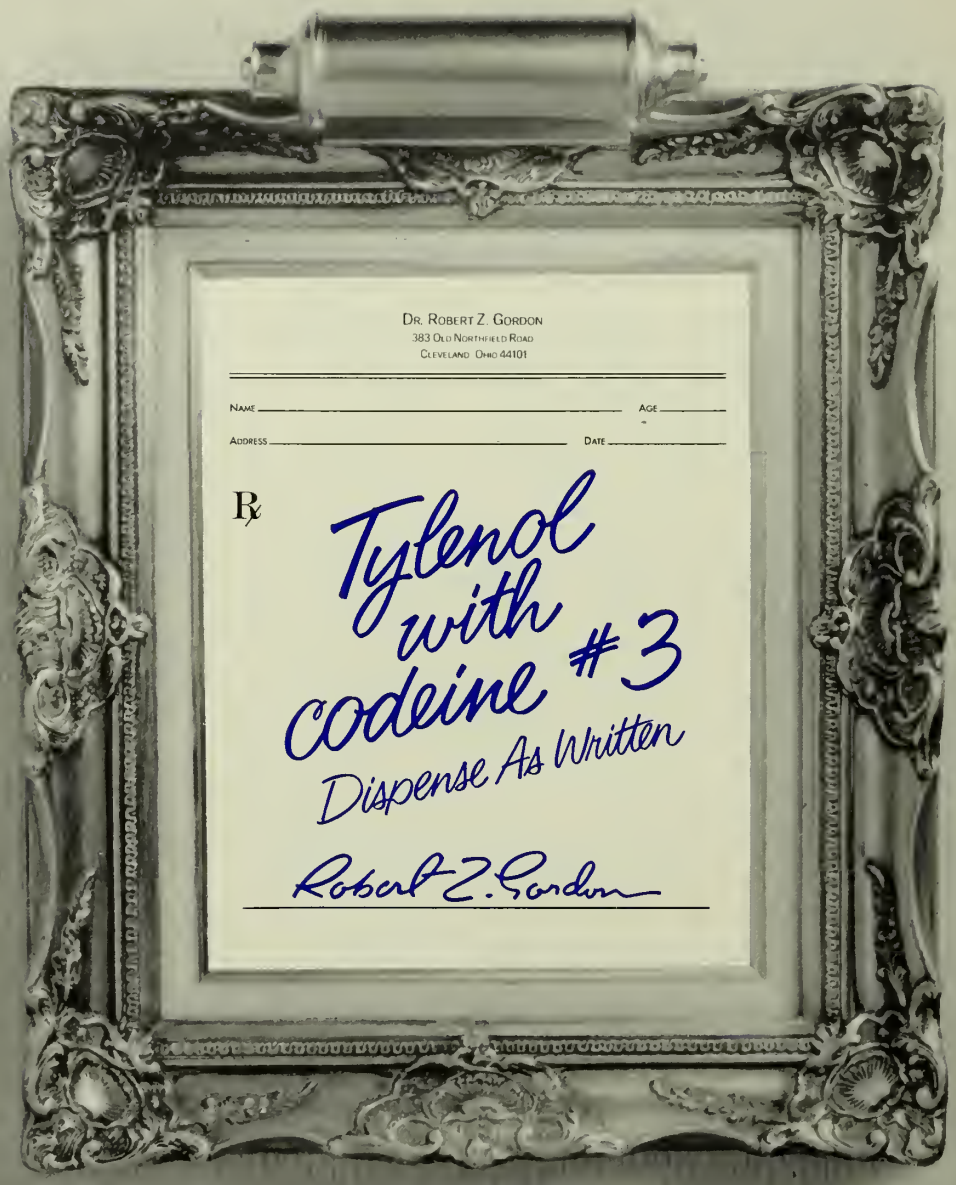
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Recently I returned from the American Medical Association Interim Meeting and never have I been more enthused and excited about the steps organized medicine is taking to combat and confront the issues facing it. The meeting was entirely interlaced with our being the advocate for our patients. Too often the association is considered as being self-centered and only interested in the economical aspects of the physician. Never has it been so evident as to the patient advocacy of the organization than at this particular meeting.

There were eight reference committees which handled issues of extreme importance from those having to do with medical education, nursing education, physician manpower, utilization review and quality review as it affects our patients to scientific aspects ranging from testing for human T cell, lymphathrophic type 3 antibodies to teenage pregnancies. There were campaigns against smokeless tobacco use, and smoking, and campaigns in support of immunizations, and the use of animals in teaching and research. Other committees focused on peer review organizations and their regulations — particularly where they affect patient care, and the abuses of PRO regulations and decisions and methods of appeal. Other public-oriented activities were those that involved hand gun violence, use of protective head gear in activities, media advertising and public service announcements regarding contraception and safe sexual practices, scientific issues in drug testing, and reports on missing and exploited children.

Many, many other issues were considered during this four day meeting with much discussion at the reference committees and from the floor of the House of Delegates. The House of Delegates was made up of some 400 physicians representing all of the states, the specialty societies, the medical staff section, the residents and interns, the medical school section and the medical directors of insurance companies and group practices.

In the near future you will be able to read a more full account of the meeting in this journal and also in the AMA News. I would hope that all of you will look closely upon the actions taken at this meeting. It really was a demonstration of action for physicians and also for our patients.

Another issue that was discussed was the recent recommendation of the Office of Management and Budget that physicians be placed under DRGs for hospital services rendered to Medicare patients. This was to be presented to President Reagan as part of the Gramm-Rudman deficit budget act. The physicians at this particular meeting flooded Washington with phone calls and a delay in the deliberations were accomplished for further study. It has been stated that Doctor Bowen, as HHS Secretary, and Doctor Roper as his HCFA administrator, are both against this method of payment to physicians and I believe that we certainly had an impact with the White House and were able to show strong support for Doctor Bowen and Doctor Roper to carry out their fight against this particular change.

This was your organization in action. I wish that many of you could have been there to see it and to be a part of it. Those of you who are not members or part of the organization should certainly reconsider your thoughts on your membership, and those of you who are members should consider getting more involved. Try to enlist your cohorts to join the organizations so that medicine can present a united and unified front. Now may be the time for non-members to stop riding the coattails of members.



John E. Albers, M.D.
President, OSMA

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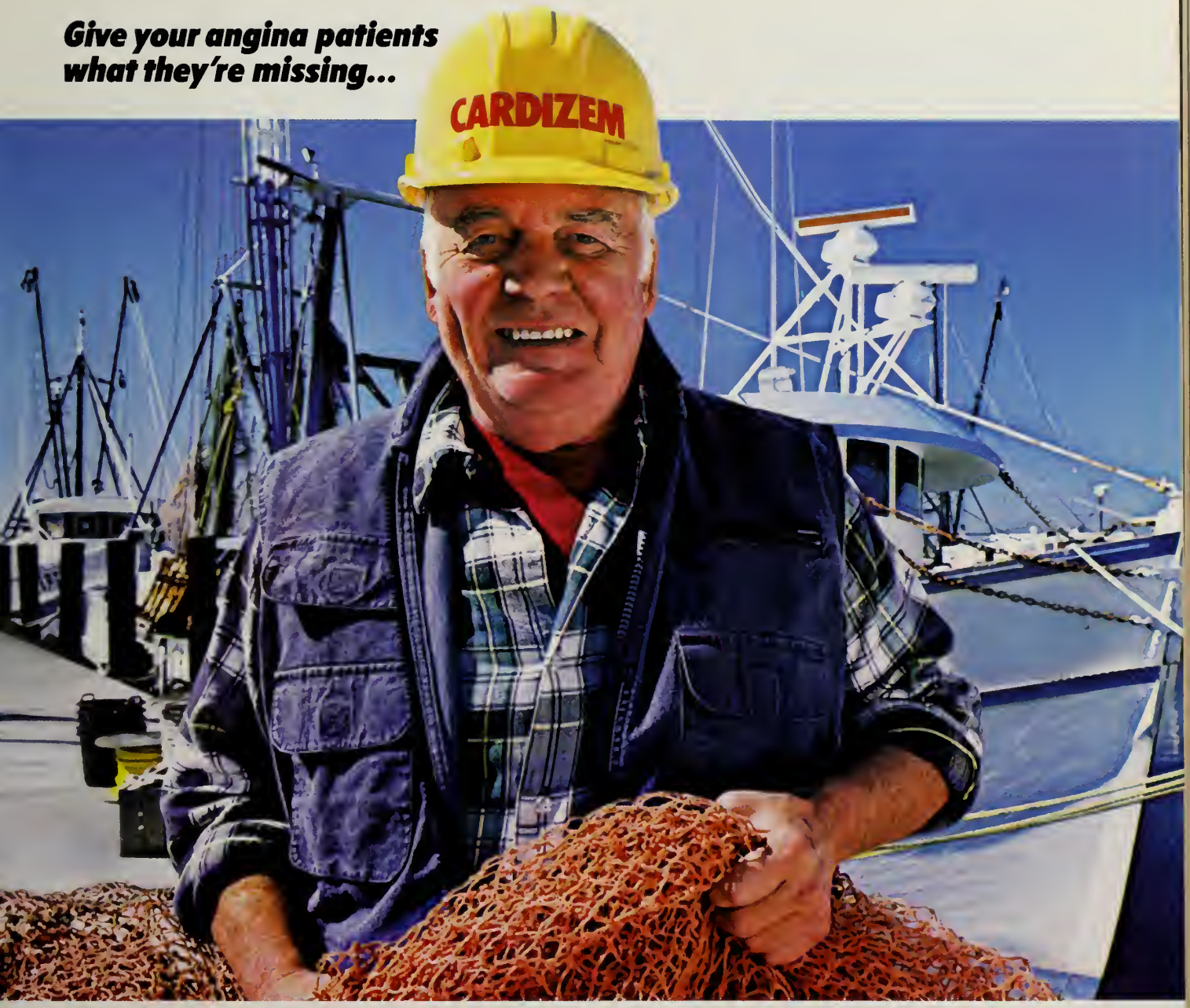
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WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS
General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes, however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/posthatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women, therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

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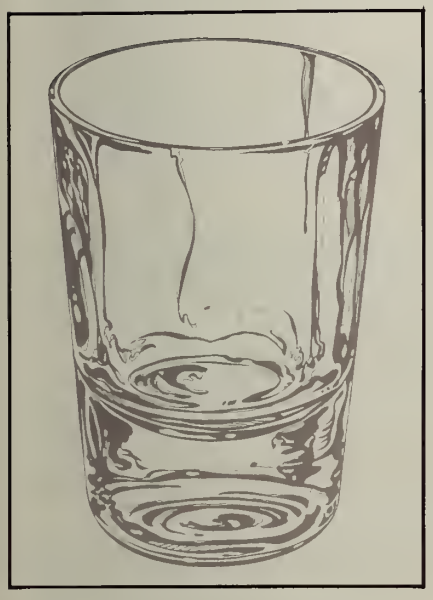
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Impaired Physicians

By Edward T. Carden, MD

From an epidemiological perspective, impaired physicians are a "special population" because 1) Their unsuspecting patients are especially vulnerable to their impaired professional performance; and 2) They have much easier access to opioid pharmaceuticals and consequently these chemicals are the drug of choice for physicians much more frequently than the general population.

Because its anti-cholinergic properties eliminate drowsiness in chronic users, Demerol is the classic drug of choice for physicians who may work a full, even hectic schedule despite a florid addiction. Indeed, the presenting symptom to casual observers may be a seizure that occurs when toxic doses are reached by the tolerant addict. However, the results of intervention and treatment for addicted physicians are about the same as the general population's rate of recovery from alcoholism. It is, therefore, most important to differentiate the physician addict from "street" addicts.

Imputing other special characteristics to impaired physicians can be very dramatic but has little basis in fact. For example, there are no worthwhile statistics to support the contention that there is a higher incidence of impairment among physicians than the general population. Such statements usually infer that chemical impairment is due to stress, but most recent studies demonstrate that stress relates to chemical impairment the same way water relates to typhoid fever.

Anesthesiologists comprise at least twice their proportionate percentage in every large series of impaired physicians; psychiatrists and emergency room physicians are often slightly over-represented, but there are no other consistently significant statistical correlates. The New Jersey Impaired Physicians Program, which is now four years old and seeks to identify any and all types of impairment, has 3% of the state's physicians in its program. No other state program can approach that mark of effectiveness. There has been a relatively constant 2:1 incidence of chemically induced problems to other impairments (psychiatric — 19-23%; physical — 1-2%; and senility — 7-9%).

In 1975, the Medical Association of Georgia endorsed a project for impaired physicians to be directed from the Ridgeview Institute in Smyrna, Georgia. Under the dynamic leadership of G. Douglas Talbott, MD, Ridgeview has treated well over 1,000 chemically

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A relapse is considered therapeutic when it constitutes "one last shot" at controlling drug intake which immediately fails, and then reinforces the person's awareness of the need for total abstinence.

dependent physicians. As of a year ago, only 125 were from Georgia, and the remainder were fairly proportionately distributed across the United States and Canada.

Dr. Talbott was the original proponent of treating physicians differently than other chemically impaired people. He feels the results of treatment for physicians are much improved when the patient population is exclusively or mostly physicians. He also believes that 120 days of treatment are necessary for most physicians to have a reasonable prognosis. He supports his theses with statistics that indicate a phenomenal success for his program in Smyrna. However, accurate follow-up for chemically dependent patients is extremely difficult and very expensive, exponentially so for a geographically dispersed group. Dr. Talbott never delineates his surveillance methodology in any of his publications, and it is therefore not possible to judge the accuracy of his statistics. This has generated widespread skepticism about his ideas as well as his results. Indeed, the Medical Association of Georgia has already cut their funding once, and is currently reevaluating its relationship with Ridgeview again.

While many of Georgia's "graduates" honestly believe they would not have succeeded without prolonged treatment surrounded by other recovering physicians, many experts reserve lengthy treatment programs for those physicians who have far advanced addictions and very little family or professional support. David I. Canavan, MD, Medical Director for New Jersey's Impaired Physician Program, has recommended prolonged treatment for only 20 of his 360 clients. His experience validates those studies that claim that high quality, intense monitoring, along with appropriate aftercare are much more beneficial than the length of inpatient treatment. Because the surveillance is so good, he has confidence that relapses will be detected rapidly. He may then recommend prolonged treatment for those clients whose relapses were not "therapeutic." A relapse is considered therapeutic when it constitutes "one last shot" at controlling drug intake which immediately fails and then reinforces the person's awareness of the need for total abstinence.

In Ohio, because we do not yet have anyone like Dr. Canavan and his staff, monitoring has often been done by the treatment centers, which may report noncompliance to the Ohio State Medical Board. Many experts feel that combining "police work" with therapy inevitably decreases the ultimate effectiveness of the therapy. No one doubts the need for monitoring and therapeutic contracts, but when done by someone independent of the treatment center, there can be no perception of a conflict by the patient or anyone else.

Surrounding an impaired physician with peers may or may not increase comfort during the initial stages of treatment. However, the goal of therapy is to convince our sick colleagues that they share the same humanity as our patients, that our humanity is the source of both our strength and our weakness, and that we must discard our "M. Deity" syndrome if we are to achieve any real fulfillment. The theory that physicians will recover more thoroughly when grouped together seems to presuppose such occupational deference that it could be more difficult to induce the humility necessary for them to see things as they really are.

In summary, the problem of the impaired physician is the same as our culture's problem with anyone else that is impaired; namely to create a system that identifies the primary subject early, and then induces therapeutic alternatives instead of allowing the natural progression of the impairment which occurs when it is ignored.

Edward T. Carden, MD, Cleveland, is the vice-chairman of the OSMA Committee on Impaired Physicians and the Physicians Effectiveness Program (PEP).

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of Ohio Medicine *or the Ohio State Medical Association.*

Do you have a cause you would like to support? A grievance you wish to air? Why not write a "Second Opinion"? Send your contribution to: The Executive Editor, Ohio Medicine, 600 S. High St., Columbus, Ohio 43215.

OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians.

"Special Needs" catalogue available

Radio Shack, a nationwide audio-video-electronics retailer, has issued its first catalogue which specifically caters to the needs of the impaired. The 32-page magazine-sized publication, "Selected Products for People with Special Needs," is available by mail from Radio Shack headquarters in Fort Worth, Texas.

The items featured are available at most of the 7,000 Radio Shack outlets nationwide.

Many of the products featured are designed to aid persons with hearing or sight problems. Among the devices are phone flashers which light up when the telephone rings and oversized number buttons on telephone instruments. Also mentioned are such items as hand tools designed to be usable with one hand; an emergency message dialer, which, with the press of one button, automatically dials up to three pre-selected numbers and plays a recorded message when the call is answered; and a portable FM room monitor which allows home care-givers to keep an eye on their "patients."



The catalogue also offers digital fever thermometers and a digital pillbox timer that beeps when it is time for medications.

Free copies of the Special Needs catalogue may be obtained by writing: Radio Shack Circulation Department, 300 One Tandy Center, Fort Worth, Texas 76102.

Exercise program: not for Parkinsonians only

An exercise program developed for Parkinson's disease patients is helping thousands of non-Parkinsonian older Americans to keep physically fit, according to the United Parkinson Foundation.

"The Exercise Program" was developed by rehabilitation-oriented physical therapists under the supervision of the UPF's Medical Advisory Board. "We've discovered that many people who do not have Parkinson's disease have ordered copies and are using our programs," says Harold O. Klawans, MD, President of the Chicago-based international organization.

Dr. Klawans points out that the program helps people with poor circulation, diabetes, hypertension, hypercholesterolemia, as well as aging heavy smokers. "It's a perfectly good fitness program for any older adult," he says.

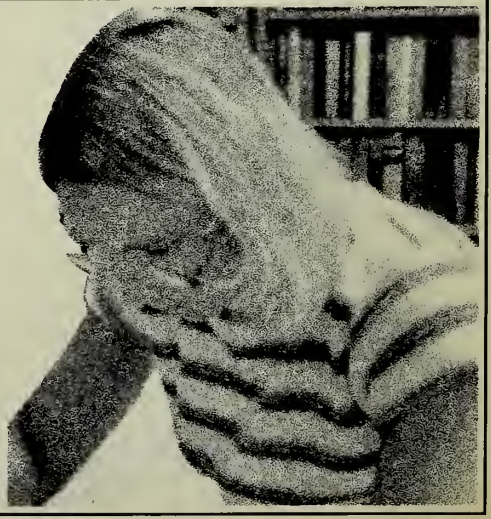
People seeking additional information should contact the United Parkinson Foundation at 360 West Superior Street, Chicago, Illinois 60610.

Teenage suicide rates decline

The teenage suicide rate which tripled between 1950 and 1975 is beginning to decline, and should continue to decrease over the next five years.

That's the news being delivered by Richard Wetzel, a clinical psychologist at Washington University in St. Louis. Wetzel spoke recently at a news briefing sponsored by the American Medical Association and Johns Hopkins Medical Institutions.

Wetzel says the reason teenage suicide grew so tremendously during the '50s and '60s was because of a parallel increase, during that time, of teenage alcohol and drug abuse. He believes the current decline in suicides might be because of an equivalent decline among young people involved with substance abuse. Using new studies which show external factors influencing a population's suicide rate, Wetzel has made a mathematical prediction that the rates will go down about 7% in the next five years.



Edited by Deborah Athy

The case of the heartsick bigamists

Not only is three a crowd, it can also be hazardous to your health, according to the conclusions of a recent letter published in *JAMA*.

Researchers from the New Rochelle Hospital Medical Center in New York, who have been studying risk factors for atherosclerosis and myocardial infarction, believe they have singled out a particular source of stress as a contributing factor to coronary heart disease because of the similar circumstances of two cases.

Case No. 1: A 53-year-old man with angina caused by acute myocardial infarction was admitted to the hospital. On the morning after admission, his devoted wife paid him a visit. Shortly after this, his fiance showed up. Fiance? Why, what's going on here? There may have been something in the works, but it didn't last much longer. The patient died shortly afterward from severe coronary artery disease.

Next, **Case No. 2:** A 34-year-old man presented with massive myocardial infarction. Shortly thereafter, he was visited by his wife-to-be. The same afternoon he received another visitor — a woman who claimed to be his fiance. His condition deteriorated, and he awaited diagnostic left ventricular catheterization, the article stated.

Government offers loan repayment benefit to certain specialists

Congress has enacted a loan repayment program to encourage physicians in certain medical specialties to serve in the reserve components of the Armed Forces.

For each year of satisfactory service in the selected reserve, the federal government will repay loans made to the physician on or after October 1, 1975 under Part B or E of the Higher Education Act of 1965. These loans include: Guaranteed Student Loans (GSL); Federal Insured Student Loans (FISL); National Direct Student Loans (NDSL); Auxiliary Loans to Assist Students (ALAS); and Health Education Assistance Loans (HEAL). Repayment is limited to $3,000 per year and a maximum of $20,000. The loan must not be in default when the physician applies for participation in the repayment program.

To qualify, the physician must be in good professional standing, hold a valid, current medical license, and be qualified (board certified or board eligible) in one of the following specialties:

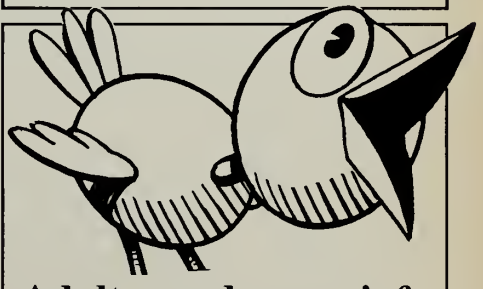
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- General Surgery
- Thoracic Surgery
- Otolaryngology
- Orthopaedic Surgery
- Neurosurgery
- Emergency Medicine

For more information, contact the Army Medical Department Reserve Personnel Office in Columbus at (614) 431-1218. Collect calls will be accepted.

New anti-depressant

Bristol-Myers Company will begin marketing its new anti-depressant BuSpar this month. Approved by the Food and Drug Administration in early October, BuSpar supposedly does not cause addiction or grogginess — problems that have often been associated with Valium, the fifth most prescribed drug in the country.

BuSpar does not take effect in the body until after a buildup of a week or two — a much different time frame from Valium, whose effect is generally felt in an hour or two.



Adults need more info on "the birds and bees"

Before parents sit down to explain the facts of life to their children, maybe they should take some time to brush up on the subject themselves. A national survey, conducted for a manufacturer of ovulation predictor tests, shows that nine out of 10 adult Americans — even those with children — don't know much about the sexual facts of life. Among the facts on which the adults were unclear are: how many days a month a woman is able to become pregnant; how long sperm live after sexual relations; and how to define ovulation. Of course, chances are good *these* days that junior could fill them in. . . .

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OHIO MEDI-SCENE

Health care for all? . . . music for the visually impaired . . . diagnosing and treating memory loss . . . for doctors only . . .

Does everyone merit health care?

A heavy smoker with lung cancer. An inexperienced skier with a broken leg. A seriously overweight heart attack victim. A 14-year-old boy injured in a gang fight. A drug addict suffering from a heroin overdose.

All of the above, to varying degrees, are responsible for their own ill health — yet no one would deny them health care based on their roles in their dilemmas. Still, with increased attention being placed today on the high cost of care and the limited resources available to pay for it, the question is repeatedly raised: Is health care automatically a right of all individuals, despite the surrounding circumstances?

The question is not a new one, says Gene Outka, professor of philosophy and Christian ethics at Yale University who spoke recently at Riverside Methodist Hospital in Columbus. In fact, it's a moral question that's been widely debated in societies around the world for years.



In Britain, says Outka, the idea that health care should be available to all citizens under all circumstances resulted in the first comprehensive government-supported health care system in the Western World. Still, "The National Health Service has its share of difficulties," says Outka. The unlimited free care promised to the British population in 1948 was soon followed by a complex system of queuing and rationing to deal with the limited resources available for the program.

In America, says Outka, citizens also embrace the concept of equal access to medical care for everyone. "There is a verbal commitment to this from all sides," he says. Yet the seemingly insatiable need for care must continually be balanced against the finite financial resources made available for this purpose.

There are certain moral aspects that must be considered if one is to answer the question: Does

OHIO MEDI-SCENE

Does everyone merit care?
continued

everyone have equal right to health care, says Outka.

These revolve around five standards of social justice which, in turn, guide the policies by which health care and other goods and services in society are distributed.

The first of these standards of justice is merit or just dessert; this comes from the concept that "people deserve to have what they have labored for," says Outka. "The fruits of their labor and their achievements are justly theirs."

On the other side of that coin, however, are those who experience problems as a result of their actions: the smoker whose lungs are diseased, the careless skier who breaks a leg or the heroin addict who overdoses.

"Yes, individuals are personally responsible for their health to a degree," says Outka. Yet who is to judge to what degree an illness or injury resulted from the patient's action? More importantly, whose responsibility is it to deny them care on that basis?

"Often health care crises are unpredictable and beyond our control," Outka points out. Unlike other human needs — food and shelter, for example, which can be planned for ahead of time — "many health crises are random and uncontrollable," says Outka. Even in those cases where behavior led to the problem, there are physical, psychological and social aspects which may be out of the individual's control — such as the fact that the heroin addict was raised in the ghetto or the overweight heart attack victim inherited his tendency for obesity as well as heart disease. Genetics, forces in nature, risk factors, even luck or fate can play a major role in determining who will suffer and who will survive — despite similar behavior patterns.

Thus merit, or just dessert, is not a standard of justice that can easily be applied to health care rights, says Outka. Even less acceptable are three of the four other standards of social justice: social contribution, supply and demand, and equality.

Social contribution implies that people should be treated according to their contribution to society — both now and in the future, Outka explains. "It's a matter of the greatest good for the greatest number of people," he says. Yet it's difficult to measure or determine what is valuable about a person. "All individuals are equal before God," says Outka. And where health care is concerned, those who are likely to contribute the least to society — the disabled and the elderly — are those who need care the most.

Likewise, a second standard, supply and demand, would allow an individual to pick and choose from a variety of benefits that

"Where health care is concerned, those who are likely to contribute the least to society are those who need care the most."

New device brings music to visually impaired

A doctoral student at the University of Toledo has engineered an innovative device for teaching music to the visually impaired.

"The Music Magni-Viewer," developed by Richard Martin Friedman, allows those with severely limited vision to play from a screen on which the musical score has been magnified 96 times. The screen sits on top of the piano (where the music stand is typically located) and can be operated either automatically, via a foot switch placed near the piano's pedals, or manually. The operating panel also contains a control button which adjusts the brightness of the image.

Friedman has recently completed tests of the device and plans to market it nationally through university and metropolitan libraries, as well as schools and agencies for the visually impaired. State trademarks for the "Music Magni-Viewer" have been granted, federal trademarks and domestic patents are pending. If you would like further information on Friedman's device, you may contact him at: 2426 Drummond Rd., Toledo, Ohio 43606; 419-473-3333.

society has to offer — health care being only one of them. Yet where health care needs are concerned, it does not apply because "the trade-offs are too great," says Outka. "When lumps appear in my neck, there is no question that I'm going to choose a doctor over a color TV set," he says.

And finally, there is the concept of equality: similar treatment for similar cases. Decisions are made on certain categories of illness, which are to be treated equally according to the resources available — not on an individual's ability to pay. What results here, however, is "a collision between needs and resources," as individuals are continuously denied care because they do not fit the designated categories.

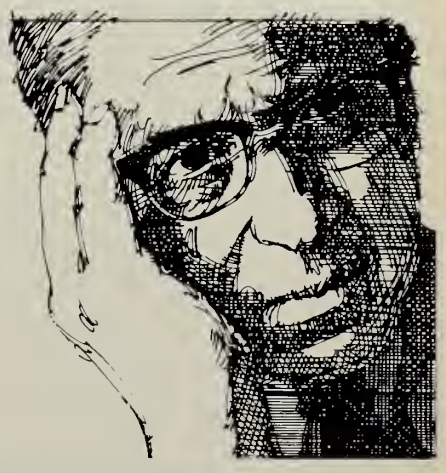
Perhaps the most fitting standard of social justice that applies to the health care field is need, says Outka. Here, however, those basic needs essential for survival (food, drink, shelter and good health) must be elevated over other needs in society, which Outka calls felt needs, wants or desires.

Still, the question of merit comes into play — if not at the critical stage when the smoker is dying or the skier is injured on the slopes — at an earlier point in time when these lifestyle decisions are being made. Incentives for responsible behavior could take a variety of forms: additional taxes on tobacco, for example, would discourage its use and at the same time build a fund to treat its victims. Special insurance policies could be made available to those involved in high-risk sports and activities.

While all individuals have a right to health care based on very real needs, "merit and individual responsibility do have some weight, because illness can be the result of voluntary human choices," says Outka. "We need to increase the penalties for negligence — levy higher taxes on alcohol and tobacco and then pump those dollars into health care programs rather than highways."

On the other hand, it would be impractical if not immoral to force physicians and other health care workers to make snap decisions at the time of a health care crisis based on who is deserving of medical attention and who is not — "to make judgments on merit in the face of catastrophe." Behavior, alone, is seldom the only cause and thus cannot be used to decide who will live and who will die. "People may be unequal in ways they cannot change," says Outka. — *Susan Porter*

Yesterday never happened — diagnosing and treating memory loss



Memory loss is threatening to become one of America's biggest health problems.

There are presently 1.3 million nursing home residents over the age of 65 who suffer from some form of cognitive dysfunction, and that figure is expected to climb to 3.5 million by the turn of the next century.

"Memory problems are not rare, especially for people in this age group," says A. Dale Gulledge, MD, section head of the department of psychiatry at the Cleveland Clinic. Dr. Gulledge recently served as moderator of "Yesterday Never Happened," a panel discussion on drug-induced and organic memory loss, presented by the Health Care Information Network.

Memory is an important part of our identity. "If we don't have a memory, we don't have a past."

Yet, as Dr. Gulledge points out, memory is an important part of our identity. "If we don't have a memory, we don't have a past."

And memory loss *can* be incapacitating.

"We forget how to do things we take for granted," he says. Activities like running the blender, finding the checkbook, even remembering friends' names and the directions home can become difficult, even impossible tasks for the memory loss patient.

Yet as frustrating as memory loss can be for the patient, it is even more frustrating for the physician who is attempting to diagnose and treat it.

The problem is that it can be caused by — or be part of — any number of things.

Head trauma, for example, which affects nearly 300,000 people per year, is a significant cause of memory problems, says Dr. Gulledge. So, too, are many neurological dysfunctions.

OHIO MEDI-SCENE

Yesterday never happened
continued

"It is unusual," says Maurice Hanson, MD, a neurologist and director of the Center of Aging at the Cleveland Clinic, "for a patient to complain of memory loss alone."

Often, other symptoms are present, and it is to these symptoms that the diagnosing physician must turn for clues. For example, says Dr. Hanson, a physician should consider:

- the onset and progression of the problem — when did the memory loss begin? In Alzheimer's, it is often difficult to determine when the problem began. When other neurological problems are present, however, it may be possible to pinpoint the date more precisely. In that case, says Dr. Hanson, look for signs of stroke, multi-infarct dementia or subdural hematomas, especially if memory waxes and wanes.
- personality changes — when these occur, look first for evidence of Huntington's disease, Pick's disease or substance abuse, suggests Dr. Hanson.
- focal neurologic symptoms — multi-focal language abnormalities are common in both Pick's disease and Alzheimer's, says Dr. Hanson. If tics and spasms are present, however, suspect a slow viral infection, like Huntington's disease.
- presence or absence of movement disorders — since motor loss is uncommon with Alzheimer's disease, Dr. Hanson suggests that the presence of a movement disorder may be due to a cerebral mass or stroke. If there is gait shuffling or rigidity, Parkinson's disease may be the problem.
- presence or absence of incontinence — urinary incontinence usually occurs late in dementia-type illnesses, says Dr. Hanson. If incontinence appears early, suspect normal pressure hydrocephalitis.

A history of any drug or alcohol use by the patient is also useful in making a diagnosis, says Dr. Hanson.

"Any drug can potentially produce memory problems," he says, adding that some over-the-counter preparations, and other drugs "which you wouldn't think affect the memory, can cause dementing illnesses."

Martin Scharf, associate professor of psychiatry at University of Cincinnati's School of Medicine, agrees.

"Physicians need to consider drug-induced involvement in their diagnosis, especially if the memory loss is acute."

"Physicians need to consider drug-induced involvement in their diagnosis, especially if the memory loss is acute," he says.

He lists some commonly used drugs with reported memory impairment:

- alpha methyldopa
- digitalis preparolos
- lithium carbonate
- monoamine oxidose inhibitors
- tricyclic antidepressants and
- beta blockers

Scharf also warns against banzodiozephine drugs with high receptor affinity, which, he says, often produce an amnesiac effect. They include: alprazolam, triazolam, clonazepam and lorazepem. "The amnesiac effect of these drugs is grossly underreported by patients who may be too embarrassed to mention it," says Scharf.

Friends and family members may not even notice the memory lapses because, while a patient is under the effect of the banzodiozephine drugs, he or she will appear to be quite normal and lucid, exhibiting no evidence of any impairment at all. The impairment doesn't become obvious until later, says Scharf.

"These patients will have no memory of a phone conversation they may have had, or a business deal they've arranged, and they can't even be cued to remember it," he comments, adding that there have been cases where persons have even committed crimes under the effect of the banzodiozephine drugs and have had no recollection of doing so.

Drug involvement, head trauma and possible neurologic disorders are not the only reasons Alzheimer's and other dementias are hard to diagnose, however.

"It is difficult to distinguish between normal and abnormal

changes which occur with age," says Gordon Chelune, a neuropsychologist at the Cleveland Clinic Foundations.

"Older individuals between the ages of 75 and 80 all complain of some forgetfulness. They'll forget where they put their keys, or get to the store and forget what they've written on their shopping list. But a breakdown in remembering is not the same as a loss of memory," he says.

Chelune defines memory as the "representation and consciousness of material which is no longer present."

To "remember," whether it's a grocery store list or an event from the past, Chelune says several steps must be taken.

First, he says, there is the acquisition of information. The information has to be acquired or learned by paying attention to the material, concentrating on it and registering it in memory.

"That's why giving a recall test to a patient is ineffective unless you ask for immediate recall to see whether or not the patient has acquired the information. He or she may not be able to recall the information they've been given, simply because they have not learned it."

The second stage of remembering is retention, where the information is stored in associative memory, and the final stage, retrieval, allows the material to be brought forth through recall and recognition. Chelune believes all stages must be present for remembering to occur.

"Problems occur, however, when patients don't make the mental effort to acquire the material. In cases of severe depression, for example, patients often lack the motivation and effort to get the information in, which is why severe forms of depression will often mimic dementia — with the same derangement of mental functions," says Chelune. Again, it's a case of let the physician beware before diagnosing dementia-type illnesses.

In examining patients with memory loss, Dr. Hanson suggests that the following basic tests be administered before making a diagnosis of Alzheimer's disease:

- CBC-ESR
- SMA-18
- VDRL (FTA)
- T-4
- B12
- CT
- EEG

At the same time, however, Dr. Hanson urges physicians to use caution when diagnosing from a CT scan.

"You must know what you're looking for, as there is a poor correlation between atrophy and the presence and absence of dementia on a CT scan. The scan will tell you, however, whether or not the problem might be hydrocephalitis."

He also recommends that patients be given a "mini" mental status exam.

"We know a common manifestation of Alzheimer's disease is that the patient will have trouble making complex drawings since there is usually some visual, spatial and construction difficulties."

All in all, says Dr. Hanson, examining memory loss patients need not be a laborious process — but it should be a thorough one. Alzheimer's disease — as with most dementias — is perhaps best diagnosed by first ruling out everything else. — *Karen S. Edwards*

For doctors only . . .

Let's face it: some things in life are trivial pursuits — which sitcom to watch, what color tie to buy, what to fix for dinner. But good communication with your patients is not one of those things.

That's where *Health Hints* — a newly designed patient education newsletter produced by the Ohio State Medical Association — fits in.

Spare just a few seconds to find out why.

So, what is it?

The patient newsletter *Health Hints* is published four times a year — fall, winter, spring, and summer — and is seasonally angled. (You may have noticed a sample of the newsletter enclosed in the OSMAgram.) Comprised of short articles covering a wide array of subjects, *Health Hints* presents your patients with the best of both worlds: the articles are concise enough so that people won't mind taking a few minutes to read them, but they are substantial enough to get people thinking about their health and their lifestyles. Hot off the press is the winter addition of *Health Hints* with highlights including: how to beat the holiday blues; how to winterize your home, your car and yourself; as well as stories on smoking on the job, football injuries, and others.

Who's it for?

Health Hints is designed with you and your patients in mind. Your name, or your group's name, and address will be printed on the front, so the newsletters function as a business card, a reminder to the patient of your name and address, as well as a continued recommendation to practice good


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For doctors only . . .
continued

health habits long after the patient has left your office. There are a number of excellent ways to utilize the newsletters — distribute them at your office or include them with your patients' bills, for example. The newsletters are accessible, too . . . something which can be easily picked up and shared by patients and their families, friends, neighbors, etc.

Why should I bother?

According to recent surveys, some 50% of the American public report that their doctors do not spend enough time communicating with them and answering their questions. Marketing experts recommend educational patient newsletters as a means to that end — a way to bridge the communication gap. A personalized newsletter is a direct and effective way of letting your patients know that you are willing to do a little extra to safeguard their good health and to supplement their health education. *Health Hints* is an extra service which complements the excellent medical care your patients are already receiving from you.

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Not only is *Health Hints* inexpensive — just $25 per 100 (for 600 or more, $22 per 100; *minimum order of 200*) — it is also very simple to order. Take a few seconds to call the OSMA, 614-228-6971, for further information or to place an order. We will bill you after you have received your shipment.

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Legislative Roundup

The Legislative Year in Review

By the OSMA Department of Legislation

On December 31, 1986, the curtain came down on the 116th Ohio General Assembly. All of the legislation which was left pending on that date officially expired, but much of it will be reintroduced as new legislation in the 117th Ohio General Assembly which officially convenes on January 5, 1987.

During the past two years of the 116th Ohio General Assembly, your Ohio State Medical Association closely monitored more than 130 individual pieces of legislation which would impact the practice of medicine and quality health care in Ohio. The legislation was carefully scrutinized to ensure that it would not impair Ohio's physicians from delivering quality health care services to the citizens of Ohio.

The OSMA's Committee on Legislation was instrumental in reviewing the many issues affecting the practice of medicine and quality health care that were introduced during the 116th Ohio General Assembly. The OSMA's Legislative Committee is Chaired by William J. Marshall, M.D. of Dayton. Members of this Committee include:

Janet K. Bixel, M.D. (Columbus)
John A. Burkhart, M.D. (Columbus)
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Mrs. Rose Vesper (New Richmond)
Richard Wisely, M.D. (Toledo).

The following article presents a synopsis of the major legislative issues from the 116th Ohio General Assembly which affects the practice of medicine.

The synopsis reports the final

continued on page 28

Medical Liability Reform Remains Priority

One major piece of legislation that remains as a priority from the final session of the 116th Ohio General Assembly is OSMA's medical professional liability reform measure, House Bill 1025. Introduced in September, 1986, by State Representative Paul Jones (D-Ravenna), House Bill 1025 was the subject of several hearings before the House of Representatives' Select Committee on Civil Justice. (An account of those hearings appeared in the November 1986 issue of the *Ohio State Medical Journal.*)

While the legislature's failure to act on House Bill 1025 was disappointing, it came as no surprise since legislative leaders had indicated from the beginning that they preferred to postpone debate on medical professional liability until the legislature resolved the general tort and insurance reform bill, Senate Bill 330. Senate Bill 330, which dealt with the more global issues of commercial and professional liability, passed the legislature but was vetoed by the Governor. Although the issue of general tort reform has not been resolved, OSMA intends to ask the legislature to tackle medical professional liability in early 1987.

The need for professional liability reform is not new to Ohio physicians or the members of the Ohio General Assembly. In 1975 the legislature stepped in to resolve the medical malpractice crisis that threatened physicians and patients alike. House Bill 682, supported by OSMA, passed in 1975 and stabilized the medical professional liability market for a brief period.

However, as most physicians know from their own personal experience, much has happened in the ensuing 11 years to weaken the Ohio law resulting from House Bill 682 and thus has created the need for new medical professional liability reform legislation.

In the 11 years since the passage of House Bill 682, the Ohio Supreme Court has eroded the intent of the medical professional liability statutes. This is particularly true in regards to the Court's treatment of the statute of limitations for medical claim cases. There has also been an increasing tendency for juries and courts to grant large awards in medical claim cases.

In the upcoming 117th General Assembly beginning in January, 1987, it is expected that the coalition of health care groups which originally endorsed House Bill 1025, the OSMA, the Ohio Hospital Association and the Ohio Osteopathic Association, will continue to work together to assure that medical liability is addressed. A broad base of other health care providers and other groups involved in the health care arena are expected to join in the effort to enact medical liability reform.

State Representative Paul Jones, vice-chairman of the House Health Committee, will be the bill's chief sponsor in the Ohio House of Representatives. His grasp of this difficult issue and his aggressive support will give medicine the advantage it needs to make this effort successful. The OSMA will be seeking the co-sponsorship of as many legislators as possible in the campaign to enact medical professional liability reform.

Medicine will have several other advantages this time around which will also help assure success. First of all, thanks to the hard work of State Representative Jones and the testimony presented to date, Ohio legislators are much better acquainted with the various aspects of medical professional liability and its implication for the future. Physicians must contact local legislators to reinforce the priority of enactment of medical professional liability reform.

Secondly, the OSMA has been developing statistical evidence to support its claims that Ohio is facing a potential "malpractice" crisis and the need to pass reform before a crisis similar to the malpractice crisis of 1975 is upon us. This information is vital to counter the claims of various groups (i.e., Ohio Academy of Trial Lawyers and Nader groups) that the liability crisis has been

manufactured by the insurance industry.

The OSMA, Ohio Hospital Association, Ohio Osteopathic Association Coalition contracted in the fall with the nationally recognized accounting firm of Tillinghast, Nelson and Warren, Inc., to gather data on the medical liability climate in Ohio. In testimony regarding House Bill 1025 before the House Select Committee in the last days of the session, representatives of Tillinghast reported that there has been a sharp increase in the severity of claims filed against physicians in Ohio. From 1981 to 1985, total payments by insurance companies to cover claims against Ohio physicians have increased by 46% annually while nationally the increase is 23%.

Tillinghast also reported that, during the same time frame, the frequency of claims filed against physicians increased at the rate of 13% annually. From 1980 to 1984 the average number of claims filed against physicians almost doubled from 1.4 claims to 2.3; and if increases continue to accumulate at 13% annually, the number of claims filed against physicians will double again in less than six years! These are averages for all physician specialties, Tillinghast's spokesperson explained, adding that obstetricians, gynecologists, anesthesiologists, and neurosurgeons have experienced the most dramatic claims increases and therefore the sharpest rises in their premiums.

Tillinghast experts concluded their testimony by noting that total Ohio premiums for malpractice insurance had increased from 1981 to 1985 at an aggregated annual rate of 16.4%. The largest increase of 47% came in 1985 as insurance companies scrambled to respond to the alarming recent increases in claims frequency and severity. From this evidence, it is clear that increases similar to those of 1985 may be in store for the future without meaningful reform of Ohio medical professional liability laws. As Tillinghast continues its search for reliable, supportive data, medicine will be on even more secure footing in presenting its arguments to the 117th General Assembly.

Representative Jones says this time around, he feels the medical professional liability bill will pass,

Major elements of medical liability reform

OSMA's medical professional liability bill, House Bill 1025, was introduced into last year's Ohio General Assembly session. Although House Bill 1025 was not enacted during the brief after-election session, the OSMA intends to actively pursue enactment of the medical professional liability reform bill in the 117th Ohio General Assembly beginning in January, 1987. The following is a brief analysis of the major provisions of the legislation.

A central provision of the bill is the statute of limitations which would apply to any medical or dental claim brought against a physician, nurse, dentist, podiatrist or hospital or its employees or agents. The bill requires that a lawsuit be brought within one year from the time the patient discovers or should have discovered the injury. There is, however, an absolute bar to bringing a suit four years from the date the act or omission occurs.

The medical liability bill also proposes to reduce the number of frivolous suits filed in medical malpractice cases by establishing a procedure for filing an affidavit with the complaint. The affidavit would declare that a physician has reviewed the medical record and has found the medical claim to be reasonable. If the statements in the claim are found to be without reasonable cause and untrue, then the plaintiff and the plaintiff's attorney can be liable to pay for the physician's attorney's fees.

The collateral source proposal in the bill would expand current collateral source statutes pertaining to medical claims to specify that damages awarded would be reduced by any payments made by any collateral source (e.g., Medicare, Medicaid, Worker's Compensation, Blue Cross/Blue Shield).

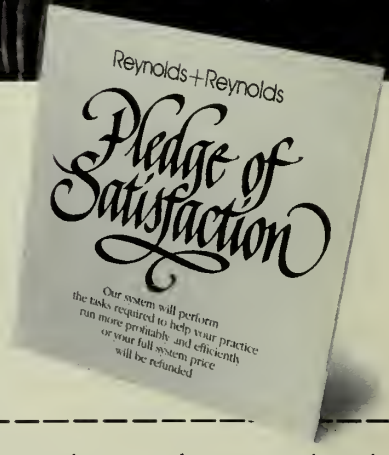
The bill would establish a procedure for the itemization of awards and, in any case where future damages awarded for both economic and non-economic loss exceed $100,000, a procedure for periodic payments to be set by the court, if requested by either party to the suit. The bill would also require that at the death of the plaintiff, all future payments would cease.

The revision of the doctrine of joint and several liability is addressed in the bill by establishing a provision whereby no joint liability would exist for any defendant found to be less than 50% negligent. However, joint and several liability would exist for any defendant found to be 50% or more responsible and who is a party at the time of judgment.

The bill would establish a contingency fee schedule for granting of attorney's fees to the plaintiff's attorney. This schedule would gauge the attorney's fee for the case to the amount of award made to the plaintiff in the case.

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adding that he plans to make it a top priority. "As a State Representative, one of my goals is to assure that Ohioans have access to affordable, high quality health care. The pending medical liability crisis will threaten the affordability, accessibility and quality of health care in this state. We must not let this happen. This problem must be addressed."

Physician Action Needed

Physicians are requested to contact their local state representative and senator to emphasize the need for medical professional liability reform early in the 117th General Assembly. Physicians should request support of the OSMA medical liability proposal and encourage legislators to sign on as co-sponsors. If you have any questions or additional information, please contact the OSMA Department of Legislation.

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continued from page 23

status of the legislation at the close of session and forecasts the likelihood of these issues reappearing in the 117th Ohio General Assembly. Medical liability reform is addressed in a separate article which begins on page 24.

General Liability Legislation

During 1986, no fewer than 35 bills were introduced in the Ohio House of Representatives and the Ohio Senate to address the global issues of the affordability and availability of liability insurance in Ohio. Among those bills, House Bill 1025 alone dealt with medical professional liability insurance. House Bill 1025 received consideration by the House Select Committee on Civil Justice during the closing days of the 116th General Assembly (see article on page 24 for further details). Reintroduction of a medical professional liability bill is one of the first orders of business for the new session beginning in January, 1987.

In the final minutes of session, the General Assembly passed a general tort and insurance reform bill, Senate Bill 330 sponsored by Senator H. Cooper Snyder of Hillsboro, but it was vetoed by Governor Richard F. Celeste shortly before Christmas. An attempt in the Senate to override the governor's veto fell one vote short of the 20 votes needed to override, so the omnibus tort reform bill died.

The tort reform provisions of Senate Bill 330 attempted to cover a broad range of issues, some of which are of mutual concern to medicine. Those issues included: 1) the expansion of the type of evidence allowable in tort actions; 2) the revision of comparative negligence laws and a general limitation on liability for multiple defendants; 3) the disclosure and deduction of certain collateral benefits; 4) the authorization of periodic payments for certain future damage awards; 5) the allowance for the recovery of attorney's fees in frivolous suits; and, 6) a request for the Supreme Court to include a rule in the Supreme Court Rules for the Government of the Bar of Ohio regarding a contingency fee schedule for attorneys. In last minute negotiations, the conference committee inserted product liability provisions into the bill over objections by the plaintiff attorneys. It was this product liability language which Governor Celeste singled out as his major objection to Senate Bill 330.

Senate Bill 330 also contained reform elements applicable to the commercial insurance industry in Ohio. The insurance reform measures, authored by Representative Michael Stinziano of Columbus, provided for: 1) the allowance of the Superintendent of Insurance to approve a change in commercial liability insurance rates before they are imposed; 2) restrictions on an insurance company's authority to terminate a contract with an independent insurance agent; 3) the allowance for banks and savings and loans to invest in Ohio-chartered reinsurance companies; 4) the codification of the Market Assistance Program (MAP) which assists Ohio commercial insurance risks in finding insurance coverage; 5) the requirement that property/casualty insurance companies provide detailed data for specific lines of coverage; 6) a prohibition of mid-term cancellations of commercial property, fire or casualty insurance, except under specific circumstances; 7) the establishment of the Ohio Commercial Joint Underwriting Association, which

will issue insurance to applicants unable to obtain coverage through the private market; and, 8) the establishment of a Joint Select Committee to monitor the effects of the tort reform and insurance reform measures established by the bill.

Although Senate Bill 330 was vetoed, its passage through the General Assembly provides the medical community an opportunity to review the reaction of the legislature, as well as the issue's opponents, regarding tort reform. This review will be invaluable as the medical community prepares its effort to pass a medical professional liability bill during the 117th General Assembly.

House Bill 494 — IPAs and Mandating Health Practitioners

One of the priority bills of the OSMA's legislative agenda for the 116th General Assembly was House Bill 494, sponsored by State Representative Michael Stinziano of Columbus. This measure, as introduced, would have mandated that physician-sponsored Independent Practice Associations (IPAs) offer equal service contracts to chiropractors, optometrists, psychologists and podiatrists. This mandate would not have applied to all other alternative health care delivery systems, such as closed-panel HMOs.

The OSMA opposed the statutory mandate this bill would have imposed on the IPAs and worked diligently with legislators and the proponents of the bill to alter the measure. With the support of the majority of the Senate Health, Human Services and Aging Committee, the OSMA was successful in having an amendment adopted eliminating the immediate imposition of the mandate, but instead establishing a study committee to undertake a six-month study of the issue of mandating providers in any alternate health care delivery system.

As amended, and passed by both the Ohio Senate and the Ohio House of Representatives, House Bill 494 now establishes a 14-member Study Committee on Participation of Health Care Providers in Alternative Health Care Delivery Systems. This study committee is composed of three state senators, three state representatives, a representative of an HMO and an IPA, and a representative of the Ohio State Medical Association, the Ohio Osteopathic Association, the Ohio Podiatric Medical Association, the Ohio State Chiropractic Association, the Ohio Psychology Association, and the Ohio Optometric Association. The Study Committee is to begin work on or before January 15, 1987 to investigate and make recommendations pertaining to the participation of health care providers in alternative health care delivery systems, and to evaluate the Ohio Revised Code sections that relate to the provision of services and participation of health care providers in alternative health care delivery systems. The Study Committee is required to issue its report on or before July 15, 1987.

Another amendment to House Bill 494 requires a health maintenance organization to set forth in its health care plan and in any solicitation materials pertaining to the plan, a statement concerning any restrictions on the choice of providers in the health care plan. House Bill 494 will be effective upon the Governor signing the bill.

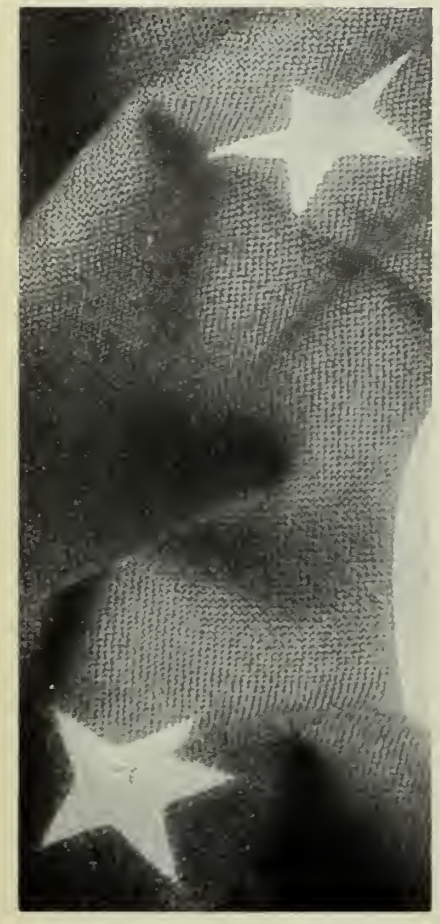
The OSMA will be an active participant in the study required by House Bill 494, which will be done during the first six months of the 117th General Assembly. Any further legislation relative to this issue will most likely be a result of the study committee which should conclude its work on or before July 15, 1987.

Medical Board Bill

House Bill 769, authored by the late State Representative John D. Thompson, Jr. of Cleveland, was a bill of significant importance to the medical community. This measure embodied an extensive review and revision of the Ohio statutes by which the State Medical Board operates and regulates the practice of medicine in Ohio.

House Bill 769, which was passed unanimously by both the Ohio Senate and the Ohio House of Representatives in the final days of the 1986 session, received considerable scrutiny from both the House Health and Retirement Committee and the Senate Health, Human Services and Aging Committee. As a result of this scrutiny, House Bill 769 is a strong bill which will significantly expand the authority of the Medical Board in licensing and disciplining physicians, while protecting the due process rights of physicians. Major provisions of the bill include:

1. Permission for the Board to issue subpoenas in investigating any alleged violation for which the Board may take disciplinary action; however, prior to the issuance of the subpoena, it must be reviewed by at least two physician board members for relevancy and timeliness;
2. The requirement that hospitals, prosecutors, and professional associations report to the Board physician misconduct and action taken against the physician;
3. The requirement that medical malpractice insurance companies report settlements and



The OSMA's Committee on Legislation was instrumental in reviewing the many issues affecting the practice of medicine.

judgments in excess of $25,000;
4. Permission for the Board to suspend licenses without a hearing if there is a showing of an immediate and serious danger to the public;
5. The provision that a physician who has been convicted of a felony involving injury to the person will have his/her license automatically suspended at the time of conviction;
6. The establishment of a mechanism for the handling of impaired physicians, both by the Medical Board and the private sector;
7. The establishment of a pilot project for clinical competency testing of Ohio residents having graduated from foreign medical schools in order to be eligible for licensure in Ohio;
8. The creation of a physicians' assistants advisory committee to the State Medical Board.

The OSMA commends the efforts of both the late State Representative John Thompson, sponsor of the bill and Chairman of the House Health Committee, and Senator David Hobson of Springfield, Chairman of the Senate Health Committee, for their diligence in development of the reforms contained in House Bill 769.

Mandatory Medicare Assignment

During the 116th Ohio General Assembly, State Representative Barbara Pringle of Cleveland introduced House Bill 962. This bill would have provided that the State Medical Board require as a condition of licensure or relicensure the acceptance of medicare assignment, if the physician agreed to provide health services to a medicare patient. This bill would have also made charging more than the "reasonable" medicare charge grounds for disciplinary action.

House Bill 962 was almost identical to the mandatory assignment bill which passed in the State of Massachusetts. Similar legislative proposals were also introduced in the states of New Jersey, Washington, California, Nevada, and Rhode Island during the 1985-86 period. Although no hearings were held on House Bill 962 during the 116th Ohio General Assembly, it is very likely that similar legislation will be introduced in the 117th Ohio General Assembly.

Revisions to the Nurse Practice Act

The OSMA spent countless hours during the 1985-1986 legislative session working on House Bill 315, which would have revised and expanded the current nurse practice act. House Bill 315, sponsored by State Representative Judy Sheerer (D-Shaker Heights), was substituted many times and by the time the sixth version of the bill was printed, the major proponents of the bill, the members of the Nursing Coalition, were asking the legislature to "kill their bill."

What happened to House Bill 315? The House of Representatives' Health and Retirement Subcommittee that had been reviewing House Bill 315 for more than a year amended House Bill 315 to change the term "nursing diagnosis" to "nursing assessment," to remove the legislative intent clause, to eliminate the establishment of an Advance Practice Nursing Council, and to delete the prescription authority for nurses. The bill would have required advanced registration nurse practitioners to provide services under the supervision and direction of a licensed physician.

However, as amended, many of the provisions desired by the nurses remained intact in the bill, provisions beneficial to nursing, such as updating and expanding the scope of nursing practice, the recognition of advanced registered nurse practitioners, providing for continuing education and peer support programs, expanding the authority for the State Nursing Board to regulate the practice of nursing, updating the grounds for which the State Nursing Board could discipline licensees, and requiring the reporting of nurses for conduct that would be grounds for disciplinary action.

Although the Ohio State Medical Association was willing to continue negotiations on House Bill 315, the nurses asked that House Bill 315 be "killed" because they said it was no longer nursing's bill but was now "medicine's bill." This is a statement that the OSMA strongly disputes since House Bill 315 was amended by the members of the House of Representatives' Health and Retirement Subcommittee who believed that the amended language was more appropriate. When the amended bill was referred back to the full committee, the Ohio House of Representatives' Health and Retirement Committee complied with the nurses request and "indefinitely postponed" House Bill 315.

Another bill to revise the nurse practice statutes will be introduced in the 117th Ohio General Assembly. The Nursing Coalition is currently meeting and working on such legislation. Also, the State Nursing Board is expected to seek increased revenues in the 1987 budget bill to provide for more Board investigators and possibly to seek expansion of their authority to discipline the nursing profession. It is hoped that in the 117th Ohio General Assembly some type of compromise can be reached between the nursing and medical professions that will assure the maintenance of quality health care for the citizens of Ohio.

Hospital Privileges

During the 116th Ohio General Assembly, the psychologists and the chiropractors had legislation sponsored to expand their extent of practice into the hospital setting. House Bill 536, sponsored by former State Representative Ed Orlett of Dayton, would have required hospitals to grant house staff privileges to psychologists. Similarly, House Bill 537, introduced by State Representative Barbara Pringle of Cleveland, would have not only required hospital staff privileges for chiropractors, but would have required hospitals to allow any licensed chiropractor access to all outpatient diagnostic services offered by the hospital "in the same manner as other licensed physicians." At the time of the legislature's adjournment, neither bill had been reported by its originating committee.

It is anticipated that the psychologists, chiropractors and possibly other limited health care practitioners will join together during the 117th Ohio General Assembly to promote more actively legislation that will mandate hospital admitting privileges for such limited health care practitioners.

Other Allied Health Practitioners

During the 116th Ohio General Assembly, the OSMA was successful in amending the Occupational Therapy-Physical Therapy Board bill, sponsored by State Representative David Hartley (D-Springfield), to increase the physician representation on the Physical Therapy Section of the Board and to enable a licensed physician or anyone employed or supervised by the licensed physician to bill for physical therapy services. As a result of this legislation, which was effective July 1, 1985, OSMA members Susan Lee Hubbell, M.D. of Lima and Stephen D. Heis, M.D. of Cincinnati were appointed to the Physical Therapy Section of the Board.

A second bill, House Bill 1055, sponsored by State Representative Marc Guthrie of Newark, was introduced in the closing days of the session on behalf of physical therapists. The intent of this bill was to clarify what practice, services, and activities could be performed by other practitioners not licensed by the Physical Therapy Section of the Occupational Therapy-Physical Therapy Board. Although no hearings were held on this bill, Representative Guthrie will most likely reintroduce a similar bill in the 117th Ohio General Assembly.

Independent licensure bills were introduced in the 1985-86 legislative session for respiratory therapists, radiation therapy technologists, diagnostic radiologic technologists, nuclear medicine technologists, dietitians and hospice programs. The only licensure bills to pass during the 1985-86 session were the dietitian licensure bill and the hospice program licensure bill. The dietitian licensure bill, sponsored by State Representative Leroy Peterson of Maple Heights, passed the General Assembly in the closing days of the session and will provide for the licensure of dietitians, will create a five member Board of Dietetics, and will prohibit the use of the title "dietitian" or "nutritionist" unless a person is licensed as a dietitian

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or is exempt from licensure.

The hospice licensure bill, sponsored by State Senator Lee I. Fisher (D-Shaker Heights), was also passed by the Ohio General Assembly in its closing days. This bill will require licensure of a person or agency proposing to provide a hospice care program. Pursuant to OSMA Resolution 8-84, the OSMA was successful in having language included in the bill to provide that "any hospital contracting for inpatient care shall be encouraged to offer temporary limited privileges to the hospice patient's attending physician while the hospice patient is receiving inpatient care from the hospital." This bill also creates a 10 member Advisory Board for Hospice Care Programs and a physician with clinical experience in oncology or terminal illness will serve as a member of the Board.

Also introduced, but not enacted, in the 116th Ohio General Assembly was an allied practitioner board and licensure bill, which would have provided for licensure of respiratory therapists, radiation therapy technologists, diagnostic radiologic technologists, nuclear medicine technologists and dietitians under one board, the Allied Health Board. This proposal was sponsored by the late State Representative John D. Thompson, Jr., but was never voted out of the subcommittee of the Ohio House of Representatives' Health and Retirement Committee.

All of the other allied health practitioners are expected back during the 1987-1988 legislative session with licensure proposals. One proposal which could resurface during the 117th Ohio General Assembly is the concept of some type of Allied Health Practitioner Board. State Representative Judy Sheerer (D-Shaker Heights) has been reviewing the problem of the proliferation of licensure boards for allied health practitioners and believes there could be a more efficient mechanism for dealing with emerging allied health care practitioners, instead of constantly creating more boards. Mechanisms which State Representative Sheerer has been reviewing include some method of pre-licensure review and some type of umbrella board for allied health care occupations.

Adopted by the 116th Ohio General Assembly was a joint House and Senate resolution to create a Joint Select Committee on Podiatry to study the profession of podiatric medicine in Ohio. As a result of the resolution, the Joint Select Committee on Podiatry was established and has been meeting to study podiatric medicine, the effects of the Ohio College of Podiatric Medicine, and the practice of podiatry. As a result of this Select Committee, it is anticipated that the Podiatric Medical College in Ohio will be seeking increased funding during the 117th Ohio General Assembly in the budget bill, and that there could be an attempt by the podiatrists to expand their current scope of practice.

Emergency Medical Services

The 116th General Assembly reviewed various pieces of legislation designed to better provide emergency medical services to Ohio citizens. The OSMA provided input during the legislative proceedings on those measures which did receive attention. Three bills of significance, House Bill 222, House Bill 491, and Senate Bill 62, were passed by the Ohio General Assembly and impacted the provision of emergency medical care in Ohio.

State Representative Marc Guthrie of Newark sponsored House Bill 222, which created the Ohio Emergency Medical Services (EMS) Agency in the Ohio Department of Education. The Agency was given responsibility for the accreditation of training programs and certification and recertification of EMT-As, advanced EMT-As and paramedics. The bill, which became fully effective in June, 1986, also created the Ohio Emergency Medical Services Board, composed of representatives of organizations involved in the provision of emergency medical services in Ohio, which will advise and make recommendations to the Agency on all aspects of the Agency's responsibilities. Tom Hall, M.D. of Newark, an OSMA member, was named the Medical Director of the EMS Agency and also serves as chairman of the EMS Board. Frank Foss, M.D. of Toledo represents the Ohio State Medical Association on the Board.

Senate Bill 62, effective June 6, 1985, permits specifically trained advanced EMT-As to engage in cardiac monitoring and defibrillation, if trained in an accredited program and under

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ANOTHER EXAMPLE OF HOW THE OSMA'S LIFE INSURANCE COMPANY IS WORKING FOR YOU.

Independent licensure bills were introduced in the 1985-86 legislative session for respiratory therapists, radiation therapy technologists, diagnostic radiologic technologists, nuclear medicine technologists, dietitians and hospice programs.

medical authorization. The legislation, sponsored by State Senator Robert Ney of Barnesville, also requires that accredited training programs for advanced EMT-As include optional training in cardiac monitoring and defibrillation.

William Gates, M.D. of Cincinnati, an OSMA member, was instrumental in the passage of House Bill 491, an act establishing the mechanism for the creation and operation of an emergency 9-1-1 telephone system. A 9-1-1 number provides a universal telephone number to be used in an emergency situation to reach police, fire fighters, and emergency medical services. Where feasible, an enhanced 9-1-1 service could be made available which would automatically identify the caller's location. The 9-1-1 proposal, sponsored by State Representative Dean Conley of Canal Winchester and State Senator Richard H. Finan of Cincinnati, provided for the means of financing such systems, once agreed to by local political instrumentalities, through a combination of local revenues, customer charges, and a state tax credit. The bill became effective June 18, 1985.

Alzheimer's Disease Research

Senate Bill 256, sponsored by State Senator David Hobson (R-Springfield), became law when both the Ohio House of Representatives and the Ohio Senate voted to override a veto by Governor Richard Celeste of a section of Senate Bill 256 which authorized additional nursing home beds to accommodate persons suffering from Alzheimer's disease. Senate Bill 256 appropriated one million dollars for Alzheimer's disease research and $850,000 for respite care and the training of health care personnel who participate in the care or treatment of persons who have Alzheimer's disease. This bill will enable the Cleveland Clinic, medical schools, and hospitals that are primary affiliates of a medical school to apply for a research grant to operate a diagnostic and research center for Alzheimer's disease. The bill also established an 11 member Alzheimer's Disease Task Force to assist the Director of the Department of Aging with the granting of the research grants. OSMA members appointed by the Governor to this Task Force include: Roy Donnerberg, M.D. (Columbus), Maurice Hanson, M.D. (Cleveland), Leopold Liss, M.D. (Columbus), Sherry Stanley, M.D. (Dayton), and Albert Tsai, M.D. (Ravenna).

Anatomical Gifts and the Continuance of Certificate of Need

During the last week of the Senate Session, House Bill 770, sponsored by State Representative Ronald J. Suster (D-Cleveland), was brought to a vote in the Ohio Senate. House Bill 770 was passed by the Ohio Senate and requires hospitals to establish an organ and tissue procurement protocol for requesting anatomical gifts. The bill also requires the protocol to identify appropriate circumstances under which requests for organ and tissue donations can and cannot be made and requires that families of potential organ and tissue donors be informed of the option to donate tissues and organs. A similar provision has been passed by the United States Congress, to be effective October 10, 1987, and requires a hospital that participates in Medicare or Medicaid to establish written protocols for the identification of potential organ donors.

Prior to passage, House Bill 770 was amended to authorize the Ohio Department of Health to continue the certificate of need program until July 1, 1987. The United States Congress had recently repealed the state health planning programs that had provided for the certificate of need program and since Ohio law on certificate of need was dependent on the existence of federal legislation, this amendment was necessary if the program was to continue. However, a restriction was placed in this amendment, which stated this provision was only to be effective until July 1, 1987, in order for the Ohio General Assembly to decide whether this program should be continued.

A second amendment was placed in House Bill 770 to create a legislative Certificate of Need Study Committee to review the effectiveness of state health planning and the certificate of need program. This legislative



William Gates, MD, of Cincinnati, an OSMA member, was instrumental in the passage of House Bill 491, an act establishing the mechanism for the creation and operation of an emergency 9-1-1 telephone system.

study committee will be composed of three Ohio senators and three members of the Ohio House of Representatives, and the Directors of Health and of Mental Health will serve as non-voting members. The Study Committee is required to submit a report on its conclusions and recommendations for legislation on or before April 15, 1987.

Finally, a third amendment was attached to House Bill 770 to provide some restrictions on a certificate of need that was issued for Alzheimer's disease nursing homes under the Alzheimer's disease legislation, Senate Bill 256.

Following the Ohio Senate's approval of House Bill 770, the amendments that were made to the bill were concurred in by the Ohio House of Representatives. A second bill introduced in 1986 pertaining to anatomical gifts, House Bill 796 sponsored by State Representative Dean Conley (D-Columbus), was "indefinitely postponed" last spring when Representative Suster's bill was passed out of the Ohio House of Representatives' Health and Retirement Committee.

Alternative Treatments for Breast Cancer

House Bill 415, sponsored by State Representative Francine Panehal (D-Cleveland), did not pass this session. This bill would have required a physician to provide a patient with a copy of a standardized written summary, prepared by the Ohio Department of Health, of the efficacious methods for the treatment of breast cancer that may be "medically viable" before a patient consents to treatment for breast cancer. This bill would have also mandated a "consent for breast biopsy" form and/or a "consent for breast surgery" form to be executed prior to a physician or surgeon performing a breast biopsy or operating on a patient for a tumor of the breast.

In response to this legislation, Richard B. Reiling, M.D. of Dayton, the President of the Ohio Chapter of the American College of Surgeons, has asked the Cancer Committee of the Ohio Chapter of the American College of Surgeons to prepare a brochure on the medically viable alternative treatments for breast cancer. The Cancer Committee is chaired by John Peter Minton, M.D., Ph.D. of Columbus, and includes: Prabir K. Chaudhuri, M.D. (Toledo), Donna L. Stahl, M.D. (Cincinnati), Margaret Dunn, M.D. (Dayton), Joseph P. Crow, M.D. (Cleveland), and Martin B. Popp, M.D. (Cincinnati). The Cancer Committee anticipates having this brochure prepared for distribution in the spring of 1987. It is anticipated that a bill similar to House Bill 415 will be reintroduced by State Representative Panehal during the 117th Ohio General Assembly.

Indigent Care

In 1986, three bills were introduced concerning indigent care. These bills were referred to a special Subcommittee of the House of Representatives' Finance and Appropriations. Chaired by State Representative Patrick Sweeney (D-Cleveland), this subcommitte spent much of the summer and fall of 1986 reviewing the issue of indigent care. Two of the legislative proposals were sponsored by State Representative Sweeney, House Bills 861 and 866. House Bill 866 would have expanded the medicaid program to include certain pregnant women, as well as certain ADC children under the age of 18. House Bill 861 would have created county health care access plans to reimburse providers for medically necessary health care

services provided to eligible individuals. The third proposal, sponsored by State Representative Judy Sheerer (D-Shaker Heights), was an attempt to reduce the disparity between hospitals in the amount of uncompensated care which hospitals provide and would have required hospitals in certain counties to contribute a proportional share of uncompensated patient care.

In the Ohio Senate, Senator Michael White (D-Cleveland) introduced a legislative proposal that would have established a pharmaceutical assistance program for the elderly to enable elderly needy to obtain certain prescription drugs at a reduced cost.

Although none of these provisions pertaining to indigent care passed during the 116th Ohio General Assembly, similar legislative proposals are expected to be introduced in January, 1987 to deal with this area. It is anticipated that some type of legislative proposal to expand medicaid coverage to pregnant women will be included in the budget bill in 1987.

Insurance Risk Pooling

During the 116th Ohio General Assembly, the Ohio House of Representatives' Insurance Committee formed a Study Committee on Health Insurability chaired by State Representative Marc Guthrie (D-Newark). As a result of this study committee, State Representative Guthrie introduced House Bill 1038, which would establish the Ohio Health Insurance Risk Sharing Plan through which adequate levels of health insurance coverage would be made available to individuals in Ohio who are otherwise considered uninsurable. Although the bill did not have any hearings during the 116th Ohio General Assembly, State Representative Guthrie intends to reintroduce his proposal in the 117th Ohio General Assembly.

Pursuant to OSMA Substitute Resolution 18-86, the Ohio State Medical Association has established a Task Force on High Risk Health Insurance. This Task Force will be investigating the problem of non-availability of affordable health insurance for patients who are considered by the insurance industry to be at high risk and will be reviewing State Representative Guthrie's proposal. OSMA members appointed to this Task Force include Joseph Moran, M.D. of Toledo, Kenneth B. Weise, M.D. of Columbus, James Barrett, M.D. of Lancaster, Charles J. Everett, M.D. of Sandusky, Raymond McMahon, Jr., M.D. of Massillon, and Don Radin, M.D. of Cincinnati, the Chairman of the Task Force.

Budget Bill

As is true with the first year of any biennial legislative session, the state's budget was a primary focus of the legislature in 1985. House Bill 238, authored by the House Finance and Appropriations Committee Chairman, State Representative William Hinig, included various items of interest and concern to physicians.

The 1986-1987 budget, totaling $19.9 billion, included a reduction in the state personal income tax to be implemented over a two year period while still increasing appropriation levels of approximately 18% over the last biennium's spending levels. Of specific interest to medicine was the inclusion of increased reimbursement levels for medicaid provider's fees. The $88 million line item represented an approximate 26% increase over the existing reimbursement levels and was the first such increase for physicians in the medicaid program in 12 years. These increases became effective January 1, 1986.

Medical-Ethical Issues

The 116th General Assembly was no stranger to sensitive, yet volatile medical-ethical issues. Two such issues were encompassed in House Bill 220 and House Bill 319.

The concept of a living will has been before the Ohio General Assembly, in one legislative form or another, for almost 10 years. The most recent proposal was House Bill 220, sponsored by then State Representative, now State Senator Robert Nettle of Barberton. House Bill 220 proposed requirements for the making and the implementation of a living will in Ohio. The bill would have granted immunity to physicians who comply with a living will. Another section of the bill would set guidelines for situations where no living will exists, but life sustaining treatment could be withheld.

House Bill 220 was approved by the Ohio House of Representatives, but legislative review of the measure was not completed by the Ohio Senate at the time the Ohio General Assembly adjourned the session. The OSMA, which retained a neutral position on the bill, supplied technical assistance in both chambers of the legislature. The introduction of a living will bill is anticipated in the 117th General Assembly.

House Bill 319 was introduced by State Representative Jerome Luebbers of Cincinnati to establish a parental notification procedure before an abortion could be performed or induced upon an "unmarried, unemancipated" minor. The bill did not require parental consent, only notification.

State Representative Luebber's bill was passed by both the Ohio House of Representatives and the

Although eight separate legislative proposals were introduced in 1985-86 which concerned restrictions on smoking, tobacco, tobacco products and snuff, none of these proposals passed the legislature.

Ohio Senate, but not without considerable discussion. The bill was allowed to become law on March 24, 1986, without Governor Celeste's signature. However, the statute was in effect less than a month before being challenged by the American Civil Liberties Union and, subsequently, being declared unconstitutional by U.S. District Judge Ann Aldrich. The Ohio Attorney General, Anthony J. Celebrezze, Jr., filed an appeal in the U.S. 6th Circuit Court of Appeals, but no action has yet been taken by the court on that appeal. The effect of these judicial actions is to keep this statute from being enforced.

The Governor responded to the problem of teenage pregnancy by creating the Governor's Task Force on Adolescent Sexuality and Pregnancy. The charge of the Task Force was to study the problem of teenage pregnancy and to recommend state initiatives to promote the prevention of teenage pregnancy. Antoinette Eaton, M.D. of Columbus, an OSMA member, was appointed chairperson of the Task Force by the Governor. The report of the Task Force should be completed by the first of 1987.

Animal Research

Two bills were introduced in the 116th Ohio General Assembly to limit the availability of animals for research. House Bill 36, sponsored by State Representative Don Gilmore (R-Columbus), would have prohibited the selling of pound dogs and the transfer of the custody or control of dogs or cats to any person, agency, institution or organization for the purpose of research, experimentation, testing, teaching, or practicing of surgical skills.

The second bill, House Bill 296, sponsored by State Representative LeRoy Peterson (D-Maple Heights), as introduced would have prohibited the use of animals, alive or dead, for research, testing, or experimentation, unless the animal was specifically bred for such purposes and would have prohibited the selling, giving, trading, supplying or providing of any seized or impounded animal, alive or dead, to any animal dealer, laboratory, educational institution, or other person for the ultimate purpose of animal experimentation, research, testing, teaching or demonstration. Although House Bill 296 was later amended to allow institutions engaged in teaching and research to use pound dogs if the purpose of the research was to benefit human beings or animals, the provision requiring pounds to offer dogs about to be destroyed to non-teaching or research institutions had been removed from the bill.

Neither House Bill 36 nor House Bill 296 passed this legislative session; however, it is expected that such legislation will continue to be introduced pertaining to restrictions on the use of animals for research. State Representative Peterson has stated that he does not intend to reintroduce his legislation in the 117th Ohio General Assembly.

Infectious Medical Waste

State Senator Gary Suhadolnik (R-Parma Heights) and State Representative Samuel Bateman (R-Milford) introduced separate legislative proposals in the 116th Ohio General Assembly to regulate the generation of and the storage, treatment, transportation, and disposal of biomedical waste and infectious hazardous waste. Both bills would have placed restrictions on the disposal of infectious medical waste in a physician's office and in hospitals. Although neither of these proposals passed this biennium, the 117th Ohio General Assembly will more than likely see the introduction of similar legislative proposals.

As a result of the introduction of these bills, the Ohio Department of Health formed an Ad Hoc Advisory Committee to investigate problems relating to the disposal of infectious waste. Samuel R. Lowery, M.D. of Fremont, Ohio, was designated as the OSMA representative on this Ad Hoc Committee. The Committee began meeting in September, 1986, and is expected to report its findings in January, 1987. Louis Goorey, M.D., a Columbus pediatrician, addressed the Committee in November, 1986, on the disposal of infectious waste and the impact of infectious waste regulations on a physician's private practice.

Seat Belts

The OSMA House of Delegates passed a resolution in support of the mandated use of seat belts. Senate Bill 54, offered by State Senator Paul Pfeifer of Bucyrus, was passed by the Ohio General Assembly and established statutes requiring operators and front seat passengers of an automobile to



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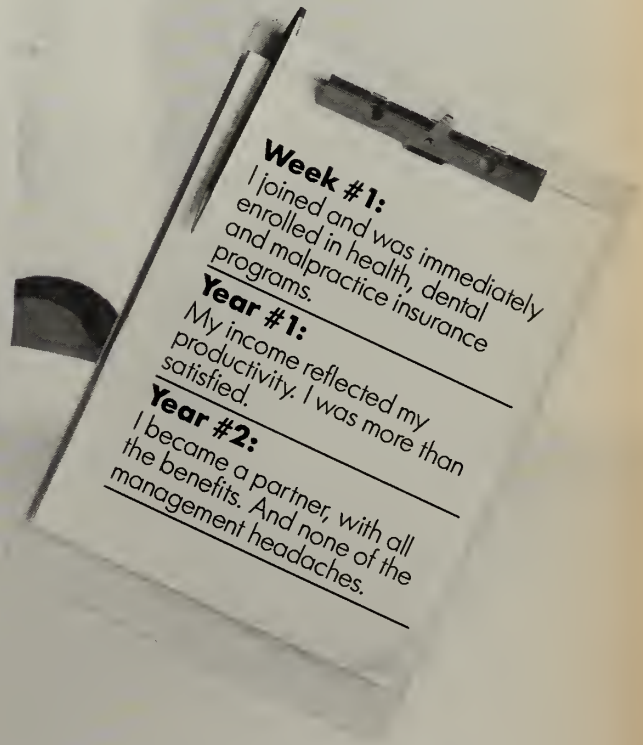
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House Bill 769 is a strong bill which will significantly expand the authority of the Medical Board in licensing and disciplining physicians, while protecting the due process rights of physicians.

wear seat belts when the automobile is in operation. The measure provides for a $20 fine for the driver and a $10 fine for front seat passengers found in violation of the law. Both the charge and the fine can be dismissed by the court if the violator views a seat belt education film prepared by the Ohio Department of Highway Safety. Persons may be charged with a seat belt violation only if stopped for another violation. Estimates by the Department are that since the bill became effective in May, 1986, seat belt usage has increased and traffic deaths have decreased.

False Insurance Claims

State Senator Eugene Branstool of Utica sponsored Senate Bill 18 establishing criminal offenses and penalties for false insurance claims. The bill, which became effective May 29, 1986, provides for a penalty of a first degree misdemeanor for fraudulent claims of less than $300 and a penalty of a fourth degree felony if the value of the fraudulent claim is greater than $300 but less than $5,000, or if the cumulative amount of fraudulent claims over a ninety (90) day period totals $300 or more. A penalty of a third degree felony would be applicable if the value of the fraudulent claim is $5,000 or more, or if the person has been convicted or pleaded guilty to more than one violation for false insurance claims.

AIDS

Only one bill was introduced during the 116th Ohio General Assembly pertaining to AIDS (Acquired Immune Deficiency Syndrome). House Bill 704 was introduced by State Representative Don Gilmore of Columbus. This bill would have required health care professionals to report the existence of a person suffering from AIDS to the local board of health, which in turn would have been required to order the isolation of the patient until the patient has recovered and is no longer able to communicate the disease to others. State Representative Gilmore indicated that he had introduced House Bill 704 to stimulate research and legislative review of this issue.

House Bill 704 did not pass this session and only one hearing was held on the bill. However, legislation pertaining to AIDS can be expected to be introduced in future legislative sessions. AIDS legislative proposals have been introduced in a number of states dealing with the following issues: confidentiality of AIDS testing; protection of the blood supply; public education; school attendance by children with AIDS; insurance discrimination; and employment discrimination.

Pursuant to OSMA Resolution 26-86, in the 117th Ohio General Assembly the OSMA will work actively to promote legislation that will make it illegal to discriminate in any fashion against any individual with a positive HTLV-III/BLOT Test. The OSMA Task Force on AIDS Discrimination includes: E. Huxley Miller, M.D. of Cincinnati, Chairman; Joan Wurmbrand, M.D. of Gahanna; Jack Summers, M.D. of Tallmadge; James B. Metzger, M.D. of Toledo; Stanley L. Fox, M.D. of Cleveland; and George Nankervis, M.D. of Akron.

Abuse and Neglect

The 116th Ohio General Assembly considered more than a dozen bills concerning abuse and neglect. Three bills which passed pertaining to child abuse and neglect were sponsored by State Representative Vernon Sykes of Akron. House Bill 349, which was effective March 6, 1986, raises the penalty for child abuse involving serious harm. House Bill 528, which was effective July 9, 1986, requires school employees to report suspected cases of child abuse and neglect. House Bill 529, which passed the last day of session, clarifies the reporting procedures for a physician in a hospital or institution to report suspected cases of child abuse or neglect, sets forth procedures and requirements pertaining to when a guardian is appointed for abused and neglected children, authorizes the guardian to bring civil actions on behalf of the child for failure to report suspected child abuse or neglect, clarifies the culpable mental state for failure to report suspected child abuse or neglect when required to do so, and clarifies when attorneys and physicians must report suspected child abuse or neglect.

The 116th General Assembly not only considered legislation involving child abuse, but dealt with adult abuse and patient abuse as well. House Bill 66, effective

March 6, 1986, sponsored by State Representative Paul Jones (D-Ravenna), was enacted to expand the list of individuals required to report suspected abuse, neglect or exploitation of adults.

House Bill 566, sponsored by State Representative Jane Campbell (D-Cleveland), was enacted authorizing the State Attorney General to investigate allegations of patient abuse and neglect in care facilities, i.e. nursing homes, sheltered housing, residential care facilities, group homes, mental health facilities and institutions, and mental retardation and developmental disabilities facilities and institutions. House Bill 566 also creates criminal penalties for certain types of patient abuse in care facilities and classifies certain types of patient neglect in care facilities as misdemeanors. This bill was effective September 17, 1986. The 117th Ohio General Assembly will likely have a number of legislative proposals introduced pertaining to abuse and neglect of children and adults.

Restrictions on Tobacco, Smoking and Snuff

Although eight separate legislative proposals were introduced in 1985-1986 which concerned restrictions on smoking, tobacco, tobacco products and snuff, none of these proposals passed the legislature. These legislative proposals would have restricted smoking in places of public assembly, except for designated smoking areas; would have prohibited the distribution of sample packages of cigarettes or



OSMA's Legislative Staff (l to r): Rick Ayish, Director; John Van Doorn; Carolyn Towner; and Kent Studebaker.

Legislative Department Profiles

The OSMA Department of Legislation serves as the Association's eyes and ears at the Ohio General Assembly for the physicians of Ohio. The Department of Legislation is staffed by Richard A. Ayish, Associate Executive Director of the OSMA and Director of Legislation; John E. Van Doorn, Director of State Legislation; and Carolyn H. Towner and Kent E. Studebaker, Associate Directors.

Rick Ayish returned to the OSMA in October, 1985 after serving as the President of Public Affairs Management, Inc. in Los Angeles, representing physicians in contract negotiations. He formerly served as a staff person in the Ohio House of Representatives in 1976, the Associate Director for OSMA's Department of Legislation from 1976-1981, and as the Senior Director of Public Affairs for the Ohio Blue Cross and Blue Shield Plans from 1981-1984. Rick has a B.S. in Journalism and a Masters in Public Administration.

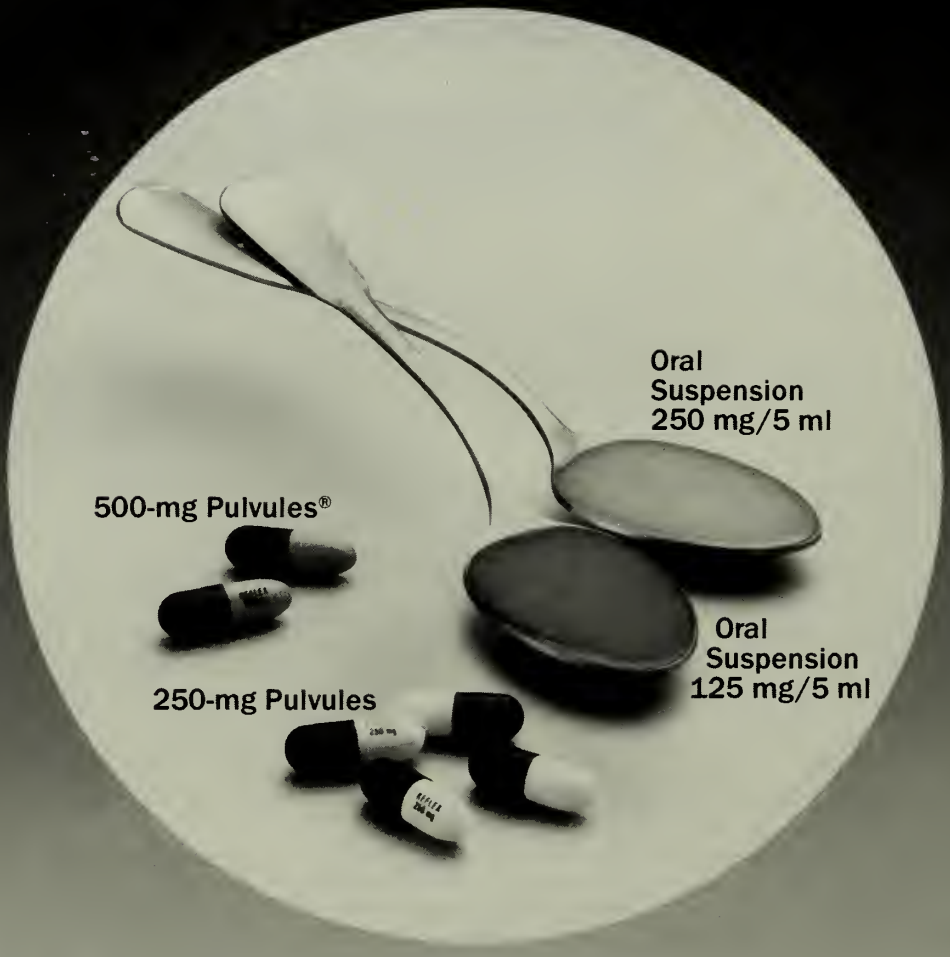
John Van Doorn joined the Department of Legislation in September, 1986. Prior to coming to OSMA, he served four years as president of the Minnesota Retail Merchants Association, a lobbying organization representing retailers at the Minnesota state capitol. Van Doorn had similar experience in Ohio where he served from 1978-1982 as public affairs director for the Ohio Council of Retail Merchants. He also served as a staff person in the Ohio Senate from 1977-1978. John has a B.A. in Political Science.

Carolyn Towner has been with the OSMA's Department of Legislation since September, 1984. Ms. Towner formerly served as the Executive Director for the Ohio General Assembly's Joint Committee on Agency Rule Review from 1979 through 1984. Carolyn has a B.A. and M.A. in Political Science.

Kent Studebaker joined the staff of the Department of Legislation in January, 1985. He formerly served as the Legislative Assistant to Senator Richard H. Finan of Cincinnati since 1977. Prior to that he served as a staff assistant for Senate Minority Leader Michael J. Maloney and as a legislative intern. Kent has a B.A. in Political Science and a Masters in Public Administration.

The OSMA Department of Legislation encourages individual physicians, physician groups, medical staffs and specialty societies to contact the Department on legislative issues and concerns. The Department of Legislation staff is available upon request to present legislative updates and briefings. Requests for information should be directed to the OSMA Department of Legislation at the OSMA office in Columbus.

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other tobacco products; would have restricted certain tobacco advertisements; would have prohibited the sale, possession, distribution or use of clove cigarettes; would have required warning labels on snuff containers; and would have enabled counties, townships, or cities to regulate smoking in places of public assembly in a more restrictive manner than currently provided in Ohio law.

Many, if not all, of these proposals will be reintroduced in the 117th Ohio General Assembly. The OSMA commends the following legislators for their legislative efforts to restrict smoking, tobacco and snuff:

State Representative Ike Thompson (D-Cleveland)
State Representative I. Ray Miller (D-Columbus)
State Representative Don Gilmore (R-Columbus)
State Representative Ronald Gerberry (D-Austintown)
State Senator Charles Horn (R-Dayton)
State Senator Eugene Branstool (D-Utica)

Other Legislative Proposals

The following bills **passed** during the 116th Ohio General Assembly:

House Bill 162 (Stinziano, D-Columbus) — Requires the annual statement of a medical malpractice insurer to contain an approved actuary's certificate stating the loss reserves for such coverage are computed and fairly stated in accordance with accepted loss reserving standards. (effective 10-10-85)

House Bill 471 (Stinziano, D-Columbus) — Expands the insurance law prohibiting false statements in connection with insurance applications and claims. (effective 7-9-86)

House Bill 476 (Tansey, R-Vermillion) — Sets forth artificial insemination requirements and establishes protection for the donor of the semen from treatment as the natural father. (effective 9-24-86)

House Bill 614 (Boster, D-Gallipolis) — Changes the name of the "Crippled Children's Services" program to the "Medically Handicapped Children's" program. (effective 9-24-86)

Senate Bill 283 (Aronoff, R-Cincinnati) — Places restrictions on autopsies if contrary to deceased's religious beliefs.

Senate Bill 307 (Finan, R-Cincinnati) — Revises statutes relative to Worker's Compensation in Ohio. (effective 8-23-86)

IN MEMORIAM — STATE REPRESENTATIVE JOHN D. THOMPSON, JR.

State Representative John D. Thompson, Jr. of Cleveland, Chairman of the Health and Retirement Committee in the Ohio House of Representatives, passed away October 15, 1986. Mr. Thompson has been a long-time friend of organized medicine and he will be missed dearly by his friends at the OSMA. Mr. Thompson had served in the Ohio House of Representatives since 1971 during which time he earned a deserved reputation as an astute politician and a fair and impartial Chairman. Mr. Thompson is survived by his wife, Doris, and two daughters.

Vermel M. Whalen, a community activist in Cleveland, was elected to the 16th House District seat in the November general election and will succeed Representative Thompson as the state representative for that house district. Ms. Whalen is a city employee and ran for Cleveland City Council during the 1970s.



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The OSMA intends to actively pursue enactment of the medical professional liability reform bill in the 117th Ohio General Assembly beginning in January, 1987.

Senate Bill 325 (Watts, R-Columbus) — Creates Medicaid Health Maintenance Organization Oversight Committee to monitor the growth and development of health maintenance organizations and alternative health care delivery systems that provide health care services to medicaid recipients.

The following bills **did not pass** during the 116th Ohio General Assembly:

House Bill 67 (P. Jones, D-Ravenna) — Would have eliminated the exemption for spiritual treatment through prayer in Ohio statutes pertaining to child neglect.

House Bill 457 (Suster, D-Cleveland) — Physician testimony regarding patient's effort to procure drugs unlawfully.

House Bill 507 (Hagan, D-Madison) — Safety regulations for boxing matches.

House Bill 533 (Miller, D-Columbus) — Hospital data collection.

House Bill 540 (Guthrie, D-Newark) — Consolidated billing for health care facilities.

House Bill 593 (Campbell, D-Cleveland) — Creates a 19 member task force to study the need for increasing the coverage provided in health insurance policies for mental or emotional disorders, and alcohol and chemical dependency.

House Bill 672 (Stinziano, D-Columbus) — Creates Ohio Poison Control Network.

House Bill 691 (Pringle, D-Cleveland) — Requires a nursing home to allow a patient, guardian, or "person in interest" to examine or obtain a copy or part of a medical record covering the patient's prior residency in the home.

House Bill 715 (P. Jones, D-Ravenna) — Registration of homemaker home health aide agencies that receive public funds.

House Bill 726 (Lawrence, R-Galena) — Autopsies for crib deaths.

House Bill 779 (Suster, D-Cleveland) — Would increase the minimum age for the consumption of beer from 19-years-old to 21.

House Bill 886 (Stinziano, D-Columbus) — Removes certain restriction on the power of hospital service associations to contract with providers of health care services.

House Bill 928 (Boehner, R-West Chester) — Student emergency medical authorization form.

House Bill 974 (Stinziano, D-Columbus) — Would convert the Ohio Joint Underwriting Association into the Ohio Patient Compensation Fund for the purpose of making higher limits of medical malpractice coverage available.

House Bill 976 (Thomas, R-Columbus) — Would have allowed a limited income tax deduction for medical care expenses.

House Bill 997 (I. Thompson, D-Cleveland) — Requires motorcycle operators to wear helmets.

Senate Bill 174 (Ocasek, D-Northfield) — Reporting procedures for corporal punishment.

Senate Bill 288 (Ney, R-Barnesville) — Data collection.

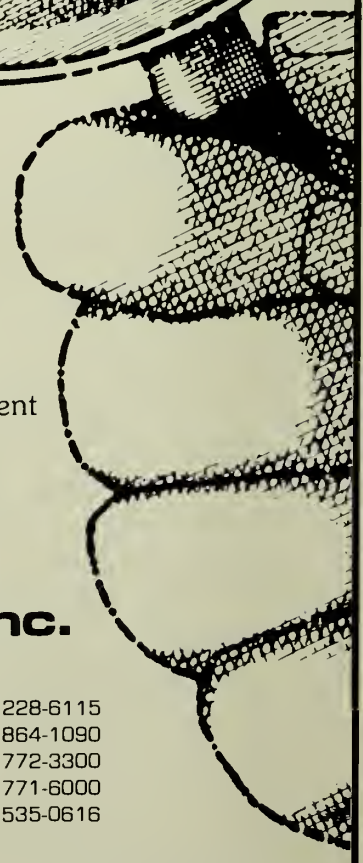
Prescription Drug Abuse

Governor Celeste named, by executive order, the Governor's Task Force on Prescription Drug Abuse. The Task Force is the result of the Prescription Abuse Data Synthesis (PADS) project sponsored by the OSMA. The project, developed by the AMA, brought together various state departments, boards, agencies, and professional associations to address the scope of prescription drug diversion in Ohio and to develop recommendations for resolving the problem.

The Governor directed the group to conduct a review of Ohio law pertaining to prescription drugs and their abuse. The Task Force was also asked to examine the regulation of impaired health care providers and make recommendations for assisting drug-dependent health care practitioners. The OSMA will actively participate as a member of the Governor's Task Force, which is to complete its work by May, 1988.

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Proceedings of the Council

SEPTEMBER 12-13, 1986

A regular meeting of the Council of the Ohio State Medical Association was held Friday, September 12 and Saturday, September 13, 1986 at the OSMA Headquarters, 600 South High Street, Columbus, Ohio.

Those present Friday, September 12 were:
John E. Albers, MD, Cincinnati
D. Ross Irons, MD, Bellevue
Herman I. Abromowitz, MD, Dayton
Joseph Sudimack, Jr., MD, Warren
Stanley J. Lucas, MD, Cincinnati
William J. Marshall, MD, Dayton
Thomas R. Leech, MD, Lima
John A. Devany, MD, Toledo
Donavin A. Baumgartner, Jr., MD, Cleveland
J. James Anderson, MD, Youngstown
Nermin D. Lavapies, MD, Martins Ferry
John F. Kroner, Jr., MD, Athens
Thomas P. Price, Jr., MD, Gallipolis
H. William Porterfield, MD, Columbus
Charles G. Adams, MD, Vermilion
Joseph L. Kloss, MD, Akron
Brian F. Jewell, Toledo, President Medical Student Section
Nora Feezel, Canton, President OSMA Auxiliary

Those present from the OSMA staff were:
Herbert E. Gillen
D. Brent Mulgrew, Esq.
Jerry J. Campbell
Robert D. Clinger
Katherine E. Wisse
Gail E. Dodson
David C. Torrens
Carol W. Mullinax
Catherine M. Costello, Esq.
William E. Fry
Carolyn H. Towner
Kent Studebaker
Doug Graff, Esq.
John Van Doorn
Rick Ayish
David W. Pennington
Doug Evans

Those present Saturday, September 13 were:
John E. Albers, MD, Cincinnati
D. Ross Irons, MD, Bellevue
Herman I. Abromowitz, MD, Dayton
Joseph Sudimack, Jr., MD, Warren
Stanley J. Lucas, MD, Cincinnati
William J. Marshall, MD, Dayton
Thomas R. Leech, MD, Lima
John A. Devany, MD, Toledo
Donavin A. Baumgartner, Jr., MD, Cleveland
J. James Anderson, MD, Youngstown
Nermin D. Lavapies, MD, Martins Ferry
Thomas P. Price, Jr., MD, Gallipolis
H. William Porterfield, MD, Columbus
Charles G. Adams, MD, Vermilion
Joseph L. Kloss, MD, Akron
Brian F. Jewell, Toledo, President Medical Student Section
Oscar W. Clarke, MD, Gallipolis, Chm., AMA Delegation
Nora Feezel, Canton, President OSMA Auxiliary
Donald R. Goodwin, Senior Vice President PICO
Thomas J. Halpin, MD, Director Ohio Department of Health
James L. Henry, MD, Chm. Task Force on Professional Liability
Marcus Wigser, MD, Cincinnati, Chm. Committee on Judicial and Professional Liability
Bill Todd, Porter, Wright, Morris & Arthur

Those present from the OSMA staff were:
Herbert E. Gillen
D. Brent Mulgrew, Esq.
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Catherine M. Costello, Esq.
William E. Fry
Carolyn H. Towner
Kent Studebaker
Doug Graff, Esq.
John Van Doorn
Rick Ayish
David W. Pennington
Doug Evans

Dr. Albers opened the meeting by asking for a moment of silence in memory of C. Douglass Ford, MD, President of the Ohio State Medical Association during 1982-1983 who passed away on July 17, 1986. The Council further observed a moment of silence in

memory of Dr. Kroner's mother-in-law and Dr. Abromowitz's sister-in-law who recently passed away.

President's Remarks

Dr. Albers reported a letter from the Cleveland Academy of Medicine had been received announcing the nomination of Donavin A. Baumgartner, Jr., MD for the office of President-Elect.

Dr. Albers' remarks included reports of visits with the Ohio Academy of Family Physicians, the Ohio Radiology Society and the West Virginia Medical Association.

Dr. Albers also reported on other activities which included discussions on HCFA rules dealing with payments for pacemakers, cataract surgery and lens implants, balanced billing under Medicare and mandatory second opinions. Also discussed were activities of antivivisectionists and recent information on AIDS.

Dr. Albers reported the officers had approved the OSMA Group Malpractice Policy after being assured the concerns expressed by the Council had been appropriately resolved.

Executive Director's Report

Mr. Gillen announced that Mr. Mulgrew would remain on the OSMA staff as Managing Director.

Mr. John Van Doorn who started employment with the Association on September 1 in the Department of State Legislation was introduced to the Council.

Mr. Gillen announced that Tom Cashman had resigned his position with the Association to continue his education.

Mr. Gillen reported that as a result of PICO's six for five stock split, OSMA now has 36,000 shares of Class B stock.

A status report was given on the current activities to wind down the Physician Administrative Corporation of Ohio.

Auditing and Appropriation Committee Report

Dr. Baumgartner reported on the September 12, 1986 meeting of the Committee. He reported the Committee reviewed a preliminary draft of the 1987 budget and that a final budget would be presented at the November Council meeting.

The Committee recommended and the Council approved that appropriate advertising would be acceptable in *Synergy.*

The Committee recommended and the Council approved investing funds in PRORE, a reinsurance company being established by PICO.

Dr. Baumgartner reported the Committee is continuing its study of the OSMA telephone needs.

Committee Reports

The Council filed the minutes of the August 13, 1986 meeting of the Committee on Accreditation.

The Council approved the minutes of the OSMA-ONO-OOA Liaison Committee which included a recommendation that the Liaison Committee develop joint statements on issues of mutual interest for approval of each organizations board or council. The Liaison Committee's joint statement that "insertion of subclavian catheters should be performed only by qualified physicians" was approved.

ODH Director's Report

Dr. Halpin discussed several issues of interest to Ohio physicians including the AIDS situation in Ohio, the transplant consortium, limited maternity unit rules and the availability of influenza vaccine.

In response to a concern expressed in regard to physician certification on certain physical examination forms that an individual is free of communicable diseases, Dr. Halpin expressed his willingness to work on possible changes in the wording of the certification.

Councilor Reports

Each of the Councilors discussed current activities and concerns of the membership in their districts. The subject of dues for those members 65 and older was discussed as was a reduction in dues for physicians' spousal members. Both matters were referred to the Committee on Membership.

Dr. Marshall gave a status report on the OPEN Program. He reported the program was ready to be implemented in Lucas and Montgomery counties by the middle of October. Mr. Gillen reported the OPEN program had recently been discussed with staff from the Governor's office. (Dr. Marshall was commended by the Council for his foresight in developing this program.)

Dr. Baumgartner reported that the Cleveland Academy of Medicine had voted opposition to H.B. 974.

OSMA Auxiliary Report

Mrs. Nora Feezel, President, presented the report of the OSMA Auxiliary. She reported the smokeless tobacco campaign is getting into high gear and that it is hopeful that the Ohio Dental Association Auxiliary will join in this effort. She stated the Auxiliary would consider providing assistance in the implementation of the OPEN program.

Legislative Update

Dr. Marshall reported on the September 12, 1986 meeting of the Committee on State Legislation. He reported Senator Richard C. Pfeiffer, Jr., (D-Columbus) addressed the Committee on how physicians should interact with legislators. Senator Pfeiffer also presented an overview of the 1986 political campaign.

Mr. Ayish reviewed the current status of OSMA activities in our tort reform legislation during the remainder of this session of the legislature.

Dr. Henry discussed the activities of the Ohio Health Care Coalition for Professional Liability Reform.

Mr. Ayish discussed the House and Senate campaigns and stressed the importance of the Supreme Court races.

Mr. Ayish also discussed H.B. 494, a bill that would mandate participation by non-physicians in physician IPAs, H.B. 974, the patient's compensation fund, OMPAC, and the upcoming legislative district conferences.

Legal Developments

The Council approved proposed changes in the Cleveland Academy of Medicine Bylaws.

Mrs. Costello discussed recent Supreme Court decisions dealing with the Ohio Statute of Limitations. She further discussed recent actions of the State Medical Board.

Dr. Marcus Wigser, Cincinnati, Chairman of the OSMA Committee on Judicial and Professional Relations, addressed the Council regarding proposed activities for the Committee. Staff was directed to prepare a plan and action program for the Committee.

Mr. Fry and Mrs. Costello presented a proposal for an OSMA sponsored system to conduct review of professional fees. The Council voted to pursue the proposal with the office of the Ohio Attorney General.

AMA Delegation Report

Dr. Oscar Clarke reported the delegation would introduce a memorial resolution in memory of Dr. Ford. He further discussed Dr. Ray Gifford's campaign for reelection at the 1987 AMA Annual Meeting and reviewed the schedule of the delegation for the AMA Interim Meeting in Las Vegas December 6-10, 1986.

It was reported the AMA is paying the expense for a delegate from each state to attend the New Physician Section meeting in Las Vegas.

The Council approved paying the expenses for an alternate delegate from Ohio to attend this section meeting on the same basis as delegates and alternates to the AMA are reimbursed. The selection of the delegate and alternate to the New Physician Section will be made by the officers.

AMA/MPS Payment System

Mr. Pennington presented a proposal from Medical Payment Systems Incorporated (MPS) seeking OSMA endorsement. This system, endorsed by the AMA, will electronically manage many medical payment transactions. It entails the use of a phone terminal device and information on participating physicians and their patients. Claim information is transmitted to a central computer. Participating insurance companies and other third-party payors can electronically access claims for processing. Mr. Pennington reported this system was pilot tested in the Cleveland area and with the cooperation of the Cleveland Academy of Medicine. Staff was asked to prepare additional information on this system for consideration at the November Council meeting.

New Business

Dr. Lucas reported the Cincinnati Academy of Medicine asked the Council to consider whether the Academy can accept osteopathic physicians as Academy members when they do not wish to join the OSMA. The Council stated that the Bylaws do not permit membership in the county society without concurrently belonging to the state association.

The Council decided to sponsor a statewide symposium on "drug testing" and directed staff to develop the program.

The Council discussed the issue that is being proposed by various groups to tie mandatory assignment of Medicare claims to licensure. Various contingencies were discussed to meet this issue. Meeting adjourned.

Respectfully submitted,
Herbert E. Gillen
Executive Director

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AIR FORCE



Proceedings of The Council

Telephone Conference Call November 5, 1986

Those Council members present on the call were: Drs. Albers, Irons, Abromowitz, Sudimack, Marshall, Leech, Devany, Anderson, Kroner, Price and Adams.

Staff members present were: Messrs. Gillen, Mulgrew, Campbell, Ayish, Van Doorn, Studebaker, Costello and Towner.

Guest present: William Todd, Legal Counsel.

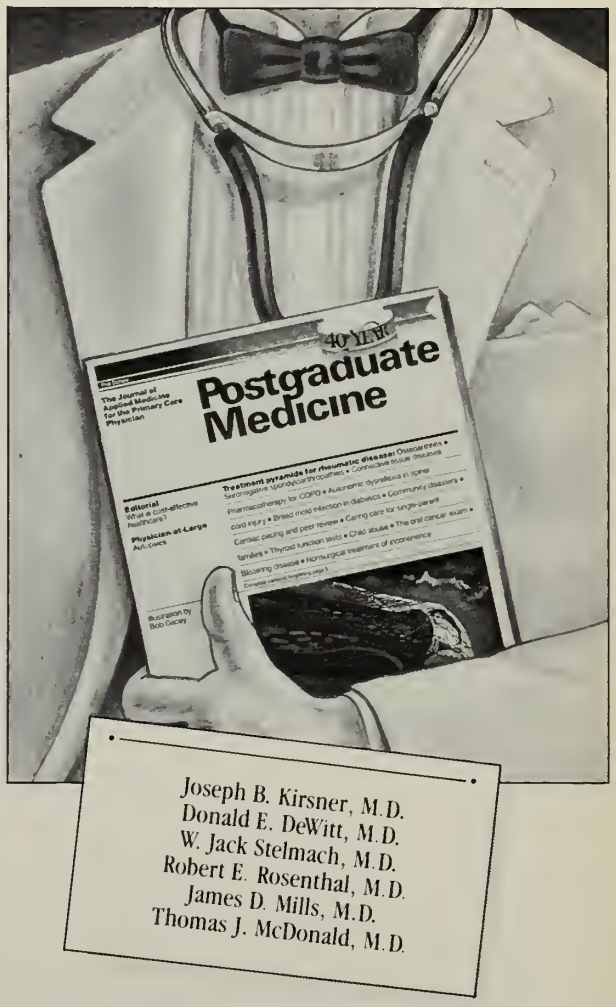
Mr. Ayish discussed the political situation surrounding the proposed malpractice tort reform legislation and Mr. Todd discussed the elements in the tort reform package that had been negotiated with representatives from the plaintiff's bar.

On motion made, seconded and unanimously carried, the Council approved the tort reform package as presented and directed that efforts be made to better define the contingency fee language.

The Council further asked that contact be made with Medical Protective and St. Paul regarding the $350,000 cap on pain and suffering.

Respectfully submitted,
Herbert E. Gillen
Executive Director

FAMOUS PHYSICIANS ARE SHOWING UP FOR OUR 40th YEAR CELEBRATION.



Joseph B. Kirsner, M.D.
Donald E. DeWitt, M.D.
W. Jack Stelmach, M.D.
Robert E. Rosenthal, M.D.
James D. Mills, M.D.
Thomas J. McDonald, M.D.

Read Every Issue From Cover to Cover:

January
Symposium: Biliary Tract Disease
Special Article: Gastroenterology 1947-1987 . . . . . Joseph B. Kirsner, M.D.

February 1
Symposium: Focus on Family Practice . . . . . Donald E. DeWitt, M.D. coordinator
Special Article: Family Practice 1947-1987 . . . . . W. Jack Stelmach, M.D.

February 15
Symposium: Emergency Medicine . . . . . Robert E. Rosenthal, M.D. coordinator
Special Article: Emergency Medicine 1947-1987 . . . . . James D. Mills, M.D.

March
Symposium: Otolaryngology in Primary Care . . . . Thomas J. McDonald, M.D. coordinator
Special Article: Otolaryngology 1947-1987 . . . . . Thomas J. McDonald, M.D.

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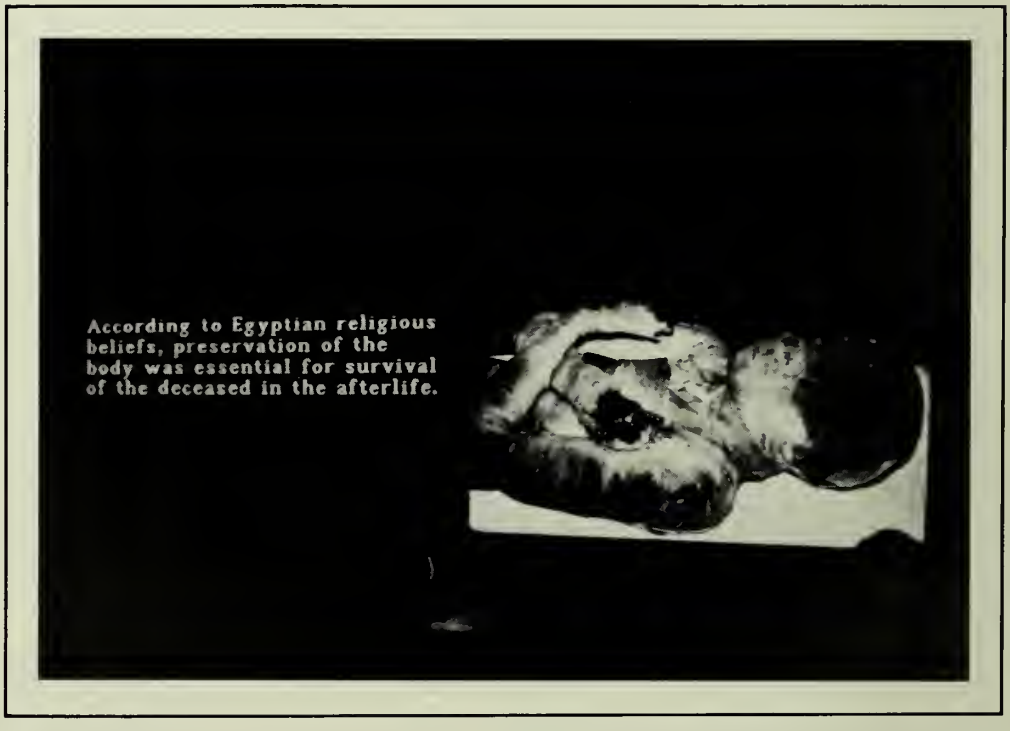
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A Glance Through Time

By Karen S. Edwards
Photos by Dennis Antle

It didn't add up. Kenneth Ostrand ran his fingers again over the bumpy hieroglyphics. The ancient symbols were telling him one thing; the crude, wooden coffin with its mummified occupant was telling him something else entirely . . .



The Ohio Historical Society's mummy is depicted with an explanation for the purpose of mummification.



Doug Haas, MD (left) and Barry Rose, MD both assisted in the x-raying project.

There *was* a way to check the facts . . . he could have the mummy x-rayed! Precedent had already been set.

An amateur Egyptologist, Ostrand had been sought out by the Museum of Natural History in Dayton to place an approximate age on its mummy — one of two given the state of Ohio during the 19th-century by J. Warden Howell, the first U.S. ambassador to Egypt (the other mummy is owned by the Ohio Historical Society). Again and again, Ostrand reviewed the facts, the physical evidence at his fingertips, but again and again, he found the facts contradicting themselves. It was as frustrating as stumbling into a richly furnished outer chamber of King Tut's tomb and reading an epitaph that begins, "Here lies a palace houseboy . . ." Somehow you know something isn't quite right.

In Ostrand's case, however, there was a way to check on the facts . . . He *could* have the mummy x-rayed. Precedence for x-raying mummies had already been set by Harvard University during the late '70s, and had been done four or five times since, by various other institutions. The Dayton mummy had even been x-rayed once before — in 1935 on a portable x-ray machine — but technology had advanced so rapidly in the meantime that surely, thought Ostrand, it would be worthwhile to do it again. He could even include the mummy owned by the Ohio Historical Society in the project — for comparison purposes — and so, late in 1984, Ostrand put together a team of volunteers to help with the fact-finding project. He included dentists, Egyptologists, and at least two radiologists from Ohio State University Hospitals in Columbus — Barry Rose, MD and Doug Haas, MD.

"The mummy owned by the Dayton Museum was in a remarkably good state of preservation," Dr. Haas told an audience of approximately 50 people who gathered at the Ohio Historical Society late last year to learn more about the project initiated by Ostrand.

Preservation, of course, is what the process of mummification is all about.

"Mummification is an artificial means designed to treat the putrification of the body," explains Dr. Rose.

At first, nothing much was required for the process. The corpse was simply placed in a pit, dug into the ground, and Egypt's finely grained sand preserved the body naturally. Then, coffins began to be used, and postmortem decay became common — much to the horror of the early Egyptians who believed a well-preserved body was essential to a successful afterlife. So they began to develop the process of mummification — a process that could take up to eight months to complete. The stages of development in this ancient Egyptian art, however, often provide scientists and historians with valuable clues in dating a mummy's time of death.

For example, says Dr. Rose, linen wrappings began to be used during the early Dynastic period, about 3100-2686 BC. Then, about 2686-2181 BC, the Egyptians began to remove the internal organs from the body.

"The entire body was soaked in natron, a salt solution, for about 40 days or longer," explains Dr. Haas, "and the organs were soaked separately in jars. These jars were then buried along with the body."

Later, about 1085-945 BC, the internal organs were still being removed, but the Egyptians now began to dry them and return them to the body before burial. Even later, a wax-like substance was applied to the corpse's mouth and neck to make them appear fuller.

"The Egyptians believed this would make it easier for the deceased to talk in the afterlife," says Dr. Rose.

During Rome's occupation of Egypt, he continues, more attention was paid to the mummy's outside appearance rather than to preserving the bodies, continues Dr. Rose.

Using these facts, then, scientists and historians can often make preliminary guesses about the time period in which the mummy was interred. However, other factors must also be considered — for example, the deceased's economic condition.

"The Egyptians used different standards of mummification, based on one's ability to pay," says Dr. Haas. If one was poor, for example, certain shortcuts were taken — for example, organs might be left in the body rather than removed, giving the impression that the body was interred several centuries before it was.

That's why today's radiologic technology has become such a valuable tool in examining these preserved bodies, says Dr. Rose. Fact is easily and neatly separated



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No Corporate Checks Please

The two Ohio mummies were x-rayed at OSU — a process that took about 19 hours and 400 CT sections.

from appearances.

The two Ohio mummies were x-rayed at OSU — a process that took about 19 hours and 400 CT sections.

"The x-rays were taken after hours," says Dr. Haas — to avoid any possibility of patients meeting mummies on the examining table.

Below are some of the facts the x-rays revealed about the Ohio Historical Society's mummy:

- The coffin had been pieced together with different types of wood — "not uncommon," says Dr. Rose, "as wood was rare in ancient Egypt," and crudely constructed "since carpentry was not advanced."
- The skull displayed a defect in the nasal septum, "probably done when the brain of the deceased was removed," says Dr. Rose. This was usually accompanied by pushing a spear-like instrument through the base of the nose to the base of the skull where the brain was "hooked" and removed.
- Teeth were worn flat, "indicating the woman was of middle-age, probably between 30 and 40."
- The mummy's arms had been wrapped separately and placed over the chest, a technique used during the late period of the Egyptian empire. Therefore, the date of the mummy's death was placed at about 800-200 BC.
- Although the chest cavity contained no heart, "there was no indication that the contents of the body had been removed." The liver, for example, was present, though dried and collapsed.
- Sand or packing material had been used to fill out the body. "This was most striking in the legs," says Dr. Rose — "which despite their appearance, were just bones with a lot of padding."

One of the more interesting facts learned about this young woman was not necessarily revealed in the x-rays, but in the hieroglyphics scratched into the coffin's side. For years, it had been assumed that the mummy had been of high rank in Egyptian society, a high priestess, perhaps, or at least a lady-in-waiting. The hieroglyphics said otherwise, however. The figural writing identified her as the daughter of a gate-keeper at one of the numerous religious temples.

Dr. Haas then proceeded with the story of Nebit-Pi, a housewife of ancient Egypt and the mummy owned by the Dayton Museum of Natural History.

- Unlike the OHS mummy, this mummy was wrapped in one continuous bundle, rather than having its arms and legs wrapped separately. "The bundle was criss-crossed with fancy blue ribbons with blue stripes," says Dr. Haas, who pointed out that it is rare for such ribbons to have survived.
- The mummy was in a remarkably good state of preservation, as has been noted earlier, and, in fact, part of its hair, which had been braided, protruded from the wrappings.
- The mouth of the mummy was open "because of the packing that had been placed there," and because of the religious significance. "It was thought that an open mouth facilitated speech in the afterlife. Often false tongues and metal lips were given as well."
- Debris in the back of the skull, revealed by x-rays, showed that the brain had not been removed — but the viscera — the lung, liver, stomach and intestines had been taken out of the body "through a left flank incision," packed in linen, resin or mud and returned to the body. "The heart was never intentionally removed," says Dr. Haas, "as this was thought to be the seat of intelligence. The Egyptians had no understanding of the brain or what it was used for."
- There had been little degenerative change in the bones, which made the researchers place Dayton's mummy as being a woman of younger age than that owned by the OHS, probably between 25 to 30 years of age.
- The mummy's fifth toe was missing — "probably an artifact," says Dr. Haas, meaning the incident occurred sometime after death.
- The fluid level in the pelvis had dried on an incline, giving rise to a theory "that the mummies were stacked 20 deep that day," suggests Dr. Haas humorously.
- Determining cause of death was not possible, "since soft tissues need to be examined, and we had none to examine," says Dr. Rose. In fact, from the x-rays the mummies appeared to be in good health.

Both mummies can be viewed at their respective museums. The Dayton Museum, in fact, has a bonus with its display — a three-dimensional model of the mummy's face, sculpted by a

A Glance through Time . . . *continued*

former OSU medical illustrationist who used the CT scan segments to piece together a replica that's believed to be 80% accurate.

Although Dr. Rose and Dr. Haas both admit to being enriched by the experience and to an awakened interest in Egypt — neither are planning any immediate archaeological expeditions to the pyramids. For the time being at least, they seem content to be working on patients who are a little younger — and a whole lot livelier. **OSMA**

Karen Edwards is the Executive Editor of Ohio Medicine. Dennis Antle is a freelance photographer from Columbus.

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Letters to the Editor . . . *continued*

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Dr. Griffin speaks directly at the issues involved in organized medicine and is certainly "on target" as he perceives the future of medicine locally, regionally, and nationally. I wholeheartedly invite him to support that organization which he unknowingly espouses: the Hospital Medical Staff Section of the OSMA.

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RELIEF OF METASTATIC BONE PAIN WITH ETIDRONATE DISODIUM

Walter Schnur, MB, BS, FAAFP

Etidronate disodium was given to 13 patients with painful osseous metastases from various primary tumor sites in an attempt to relieve their pain. At doses of 5-15 mg/kg/day, all but one patient experienced relief of pain within four weeks, as indicated by decreased intake of analgesics. Relief of pain was limited to osseous metastatic sites. In view of these clinical observations and the results of other studies of diphosphonates, randomized studies should be begun to determine the efficacy of etidronate disodium in the relief of metastatic bone pain.

Introduction

Pain is an unavoidable consequence of cancer. Although a large number of patients are cured of primary cancer, and suffer little pain, many patients with recurrent or metastatic cancer eventually develop pain which becomes progressively more severe and finally develops into a relentless suffering that greatly aggravates the physiologic and psychologic deterioration of the patient caused by the disease itself[1]. Several surveys of hospitalized cancer patients suggest that 60 to 90 percent of patients with advanced disease report substantial pain[2,3,4]. Yet all too often the diagnosis and management of cancer pain is inadequate [1,2,5,6]. The reasons commonly cited for inadequate pain relief are lack of knowledge of the basic mechanisms and pathophysiology of cancer pain and improper application of the knowledge that is currently available[1,6,7].

In the initial stage of disease, use of anti-cancer therapies provides the best approach to managing pain by treating its cause. For patients with advanced disease, when primary therapy is no longer feasible or effective, pain control should be sufficient to make the patient relatively pain-free and to allow as dignified and normal a life as possible[8,9]. Modalities in current use include systemic drugs, therapeutic nerve blocks, neurosurgical operations and psychological approaches, all of which are attempted with varying degrees of success[6].

Bone metastases are the most frequent cause of pain in advanced cancer and are common in patients with carcinoma of the breast, bronchus, prostate, kidney and thyroid, and also in multiple myeloma[3,7]. Since the growth of a bone metastasis appears to be linked to induced bone resorption[10], drugs affecting bone metabolism, for example the diphosphonates, may be required for pain control in patients with osseous metastases.

Etidronate disodium* (disodium ethane-1-hydroxy-1, 1-diphosphonate — EHDP) has been shown to inhibit bone resorption and reduce pain in Paget's disease of bone[11,12]. Moreover, etidronate disodium has a relatively strong affinity for metastatic lesions of bone (Fig. 1), further suggesting that the drug may be useful in reducing tumor-induced bone resorption. In the present open clinical study, etidronate disodium was given to patients with painful osseous metastases in an attempt to relieve their pain.

Patients and Methods

Patients who had painful metastatic carcinoma of the bone, confirmed by radiograph or biopsy, were selected to receive etidronate disodium. All patients, or their legal representatives, gave informed consent to the treatment.

Thirteen patients were treated. The primary tumor sites varied, but were typical of sites that commonly progress to bone

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* *Brand-name Didronel, manufactured by Procter & Gamble, Cincinnati, Ohio.*



Fig 1:
Bone scan using Tc99m-labeled etidronate disodium to demonstrate that the drug concentrates in skeletal metastases.



Fig 2:
Bone scans, 14 months apart, demonstrating advancing metastatic involvement, but pain was not apparent, even without analgesia (Case No. 3).

metastasis: breast (4), prostate (4), lung (1), renal cell (1) and multiple myeloma (2). In one case the primary tumor site remained undetermined.

Before treatment with etidronate disodium, all patients were receiving analgesics, including codeine, meperidine, morphine or hydromorphone, which had failed to provide satisfactory relief. The intensity of bone pain was assessed according to the daily consumption of analgesics. The initial dose of etidronate disodium varied but was generally 5-10 mg/kg/day.

Results and Discussion

The results are presented in Table 1.

With the exception of one patient, administration of etidronate disodium resulted in reduced pain, indicated by a decreased requirement for analgesics. In most cases, pain relief occurred within three weeks of initiation of therapy, and no other analgesic medication was required. Patients remained relatively pain-free, with a substantially improved quality of life, until shortly before death. In one patient, satisfactory pain-relief was maintained for over four years. In another patient, progressive pain due to spread of the disease was partially relieved by increasing the dose of etidronate disodium. In two cases, treatment was withdrawn and pain returned within three weeks. Resumption of therapy in one of these patients provided renewed relief. Pain relief was

TABLE 1.
Relief of Pain in Patients with Painful Osseous Metastases Treated with Etidronate Disodium (EHDP).

Case No.	Age/Sex	Initial Diagnosis	Dose	Time to Relief of Pain	Duration of Pain Relief	Concomitant Analgesics	Complicating Factors
1	74/M	Metastatic cancer of prostate	5mg/kg/day 5mg/kg/day	3 weeks 3 days	6 months 4 years		EHDP discontinued. Pain returned after 3 weeks. EHDP restarted. After 4 years, pain gradually returned. Carcinoma of sacral plexus nerves. Terminal state.
					2 months	Hydromorphone Meperidine	Deterioration until death. Severe pain during final month.
2	81/F	Breast cancer	5mg/kg/day	3 weeks	4 months		Death after 4 months, without pain.
3	68/M	Prostatic cancer	5mg/kg/day 15mg/kg/day	3 weeks	12 months 3 months		Advancing metastases. Knee pain. Gradual increase in dose to 15mg/kg/day. Death after 3 months. Patient hospitalized and without pain.
4	84/F	Breast cancer	5mg/kg/day	3 weeks	3 months		Death without pain after 3 months.
5	74/M	Lung cancer	5mg/kg/day	3 weeks	Until 3 months before death	Opiates	Radicular pain from extradural metastases requiring opiates. Presented as femoral lytic lesion requiring internal fixation.
6	52/F	Breast cancer	400mg bid	3 weeks	—		EHDP withdrawn by physician due to patient's complaints of thirst. Pain returned after 3 weeks and remained for duration of life. Thirst remained.
7	65/F	Renal cell cancer	400mg bid	4 weeks 8 weeks	6 months	Acetaminophen None	Death after 6 months
8	57/F	Breast cancer	10mg/kg/day 20mg/kg/day	3 weeks	3 months 6 months	 Epidural analgesia	Strontium radiation and epidural analgesia for radicular pain. By increasing dose of EHDP, dose of epidural analgesia was reduced by one-third.
9	75/M	Prostate cancer	600mg/day	2 weeks	Until death	Acetaminophen	
10	57/M	Probably amelanotic melanoma	15mg/kg/day	2 weeks	3 weeks		EHDP withdrawn following anti-tumor medication. Minimal relief. Death from uncontrollable intestinal hemorrhage.
11	85/M	Prostate cancer	10mg/kg/day	3 weeks	4 months		Death after 5 months.
12	85/F	Multiple myeloma	5mg/kg/day 10mg/kg/day	 3 weeks	 . . . to date	Acetaminophen Propoxyphene	No relief on 5mg/kg/day for 4 months. Changed to 10mg/kg/day alternate months. Patient continues on therapy.
13	85/F	Multiple myeloma	5mg/kg/day 10mg/kg/day	3 weeks No Relief	4 months	Hydromorphone Prednisone	Pain returned after 4 months. Dose increased to 10mg/kg/day for alternate months. No relief. EHDP withdrawn.

limited to osseous metastatic sites. Radicular pain and pain due to involvement of the sacral plexus nerves were not relieved by etidronate disodium, confirming similar findings[12,13].

The disphosphonates are analogues of inorganic pyrophosphate in which labile phosphorous oxygen bonds (P-O-P) are replaced by P-C-P bonds that are stable toward chemical and enzymatic degradation. They share many physicochemical properties with pyrophosphate; for example, they inhibit the precipitation of calcium phosphate and slow down the aggregation and precipitation of calcium phosphate crystals.

In experimental models, diphosphonates prevent ectopic calcification and bone resorption when tested in organ culture or in vivo.[14] Etidronate disodium inhibits ectopic ossification in paraplegia secondary to spinal cord injury and after implantation of total hip prostheses[15]. In Paget's disease, bone turnover is diminished as indicated by a decrease in both urinary hydroxproline excretion and serum alkaline phosphatase and by bone scans and bone histology[11,12].

The destruction of bone associated with metastatic invasion involves at least two mechanisms. The initial mechanism is mediated by osteoclasts. Subsequently, the tumor itself produces an osteolytic agent[10]. The osteolysis produced by both human mammary carcinoma and experimental carcinoma can be significantly inhibited by diphosphonates[16,17]. Preliminary clinical reports also indicate that diphosphonates can impair bone resorption, improve calcium balance and reduce bone pain in patients with extensive metastatic skeletal disease[16,18,19].

Reduction of pain in patients with Paget's disease has been directly related to the action of etidronate disodium on bone. A reduction of hydroxyproline and serum alkaline phosphatase levels by 30 percent or more has led to moderate to marked decrease of pain[12]. Etidronate disodium may reduce pain in patients with osseous metastases by preventing further bone resorption.

At high doses, etidronate disodium has been associated with nausea and diarrhea. In the cases presented here, the only possible side effect observed was thirst. However, since cessation of therapy did not alleviate the thirst, it is unlikely that the effect could be attributed to therapy. When etidronate disodium is given at high doses (20 mg/kg/day) over an extended period, there is a slight risk that osteomalacia may occur. Supplemental administration of 250 mg of elemental calcium (as calcium carbonate per os) q.i.d. is recommended empirically at least two hours before or after etidronate disodium.

On the basis of observations made while treating these patients, I have developed a treatment protocol that seems appropriate. Initially, etidronate disodium is administered in a single dose of 10-15 mg/kg/day until pain is relieved or for no longer than four weeks. If there is relief, the dose is then reduced to 5 mg/kg/day. If there is no relief, the medication is discontinued. If pain worsens, the dose is increased gradually to a maximum of 20 mg/kg/day. Etidronate disodium is poorly absorbed from the intestinal tract and must be given on an empty stomach in a single daily dose.

These clinical observations suggest the need for randomized studies to evaluate the potential usefulness of etidronate disodium as palliative therapy in cancer patients with painful osseous metastases.

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LONG-STANDING, ESTABLISHED FAMILY PRACTICE Residency Program seeks an Associate Director. Primary responsibility is undergraduate teaching with additional responsibilities for resident teaching and clinical practice. University associated program in Northeastern Ohio. Competitive salary and benefits. Please respond with C.V. to Carla Kachmar, Vice President — Medical Staff Services, Akron General Medical Center, 400 Wabash Avenue, Akron, OH 44307.

OHIO: Emergency Medicine positions ranging from part-time placements to full-

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We are a Columbus hospital searching for two board eligible or board certified family practitioners to take over two well-established practices of retiring physicians. Both retiring physicians have been members of our medical staff for over 20 years and enjoy a loyal following, drawing most of their patients from the Renaissance neighborhood where their offices are located. A broad range of ancillary and support services are available from the sponsoring hospital, located five blocks away.

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Columbus is the growing, centrally located capital city of Ohio. It boasts superior public and parochial school systems, many located in the numerous suburbs that surround the city, and is the home of four colleges, including the Ohio State University and its College of Medicine. Recreational, cultural, and leisure activities abound, with highlights including the Memorial Golf Tournament, Columbus Zoo, Columbus Symphony, several theatre companies, Metro Parks and more. Please send CV and references C/O Ohio Medicine, 600 S. High St., Columbus, OH 43215.

time Directorships. Low to high volume hospitals throughout the state. Guaranteed hourly rate plus malpractice insurance. Contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 26, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

OHIO, NORTHEAST/CLEVELAND: Staff position for Board Certified/prepared in emergency medicine or other primary care specialties for ED. 8000-32000 patient visits per year. Exc. compensation & benefit pkg: pd. health, life, disability, and dental ins; pension and PS plan; edu. stipend; and vac. Professional liability coverage paid by corp. Advancement to shareholder level for well-qualified individual. Please send CV to PO Box 2600, Lakewood, Ohio 44107.

ORTHOPEDIST — Excellent opportunity for orthopedist in Los Angeles suburb to join 80 member multispecialty medical group. Large fee-for-service and prepaid practice, no Medi-Cal. Excellent compensation program based on guarantee plus incentive, profit sharing and pension plan. Group provides health, dental, life and malpractice. Partnership in real estate and medical corporation available. Send CV to Wm. Shaw, Associate Administrator, Mullikin Medical Center, 17821 S. Pioneer Blvd., Artesia, CA 90701.

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Group Health Associates in searching for that particular physician interested in working fulltime (40 hours per week) in our Clifton Urgent Care Department. We have an excellent compensation package and good support services. This position requires no hospital responsibilities or continuing patient care. Please send your C.V. to Search Committee. Group Health Associates, 2915 Clifton Avenue, Cincinnati, Ohio 45220.

PHYSICIAN MEDICAL DIRECTOR for rapidly growing ambulatory care center located in a new medical complex in Cleveland suburb. Excellent compensation package with paid vacation, paid professional liability insurance and advancement possibilities. Corporation is highly aggressive, staffing many emergency departments and urgent care centers in the Cleveland area. Training in primary care medicine preferred. Please send CV to PO Box 2600, Lakewood, Ohio 44107.

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a well-established multispecialty group practice just 18 miles distant. Shareholder status in the parent group available after the first year. Very competitive starting salary with superb fringe benefits. Please reply to PO Box 95, c/o Ohio Medicine, 600 S. High Street, Columbus, OH 43215.

PRIMARY CARE PHYSICIANS. Multi-state practice association seeks BE/BC primary care physicians for unique opportunities in Pa., N.J., New England, Md., Fla., and other areas of the US. Most positions offer Monday-Friday 8 am to 5 pm schedules with up to *five* weeks paid time off. Paid malpractice. Contact or send CV to Liberty Healthcare Corporation, 399 Market Street, Suite 400, Philadelphia, PA 19106, (215) 592-7400 or outside Pa. (800) 331-7122.

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Student health opening — Due to staff retirements, Ohio University is seeking one or more experienced physicians to join the medical staff at the Ohio University Student Health Center. First position(s) available January 1, 1987 and subsequent position available September 1, 1987. Applications for January 1, 1987 position(s) will be accepted immediately. Deadline for September 1, 1987 applications is March 1, 1987. Opportunity to live in a lively small college town in a wooded rural setting and practice in a comprehensive health service, emphasizing health education and preventive care as well as primary outpatient medicine. Prefer experienced family practitioners with strong background in office orthopedics and/or gynecology. Applications from orthopedists and gynecologists will also be considered. Ohio licensure or eligibility for same is required. Nine, ten or twelve month appointments available with annual salary in $50,000 range plus fringes including no night or weekend call, excellent health, life and liability insurance benefits as well as good state retirement plan and access to numerous recreational facilities. Contact Gerald Noga, MD, Medical Director, Hudson Health Center, Ohio University, Athens, Ohio 45701-2991, (614) 593-1660. An Affirmative Action/E.E.O. employer.

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Send resume to W.J. Roberts, Director of Personnel, Massillon State Hospital, Box 540, Massillon, OH 44648, or call (216) 833-3135, ext. 223.

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BOARD CERTIFIED INTERNIST-CARDIOLOGIST, Ohio and Kentucky licenses, seeks emergency room Cincinnati, Northern Kentucky. Reply to Box No. 98, c/o Ohio Medicine, 600 S. High St., Columbus, OH 43215.

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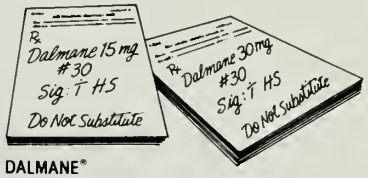
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References: **1.** Koles J, *et al: Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971. **2.** Koles A, *et al. Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Koles A, *et al. Clin Pharmacol Ther 19*:576-583, Moy 1976. **4.** Koles A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Koles A, Koles JD. *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennont FS, *et al:* Symposium on the Treotment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenbloff DJ, Allen MD, Shoder RI. *Clin Pharmacol Ther 21*:355-361, Mor 1977.



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Warnings: Coution potients obout possible combined effects with olcohol ond other CNS depressonts. An oddilive effect moy occur if olcohol is consumed the doy following use for nighttime sedotion. This potentiol moy exist for severol doys following discontinuotion. Coution ogoinst hozordous occupotions requiring complete mentol olertness (*e g*, operoting mochinery, driving). Potentiol impoirment of perfomonce of such octivities moy occur the doy following ingestion. Not recommended for use in persons under 15 yeors of oge. Withdrowol symptoms rorely reported, obrupt discontinuotion should be ovoided with groduol topering of dosoge for those potients on medicotion for o prolonged period of time. Use coution in odministering to oddiction-prone individuols or those who might increose dosoge.

Precautions: In elderly ond debilitoted potients, it is recommended thot the dosoge be limited to 15 mg to reduce risk of oversedotion, dizziness, confusion ond/or otoxio. Consider potentiol oddilive effects with other hypnotics or CNS depressonts. Employ usuol precoutions in severely depressed potients, or in those with lotent depression or suicidol tendencies, or in those with impoired renol or hepotic function.

Adverse Reactions: Dizziness, drowsiness, lightheodedness, stoggering, otoxio ond folling hove occurred, porticulorly in elderly or debilitoted potients. Severe sedotion, lethorgy, disorientotion ond como, probobly indicotive of drug intoleronce or overdosoge, hove been reported. Also reported: heodoche, heortburn, upset stomoch, nouseo, vomiting, diorrheo, constipotion, GI poin, nervousness, tolkotiveness, opprehension, irritobility, weokness, polpifotions, chest poins, body ond joint poins ond GU complaints. There hove olso been rore occurrences of leukopenio, gronulocytopenio, sweoting, flushes, difficulty in focusing, blurred vision, burning eyes, tointness, hypotension, shortness of breoth, pruritus, skin rosh, dry mouth, biffer toste, excessive solivotion, onorexio, euphorio, depression, slurred speech, confusion, restlessness, hollucinotions, ond elevoted SGOT, SGPT, totol ond direct bilirubins, ond olkoline phosphotose; ond porodoxicol reoctions, *e g*, excitement, stimulotion ond hyperoctivity.

Dosage: Individuolize for moximum beneficiol effect. *Adults*: 30 mg usuol dosoge; 15 mg moy suffice in some potients. *Elderly or debilitated patients:* 15 mg recommended initiolly until response is determined.

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Please see adjacent page for references and summary of product information.

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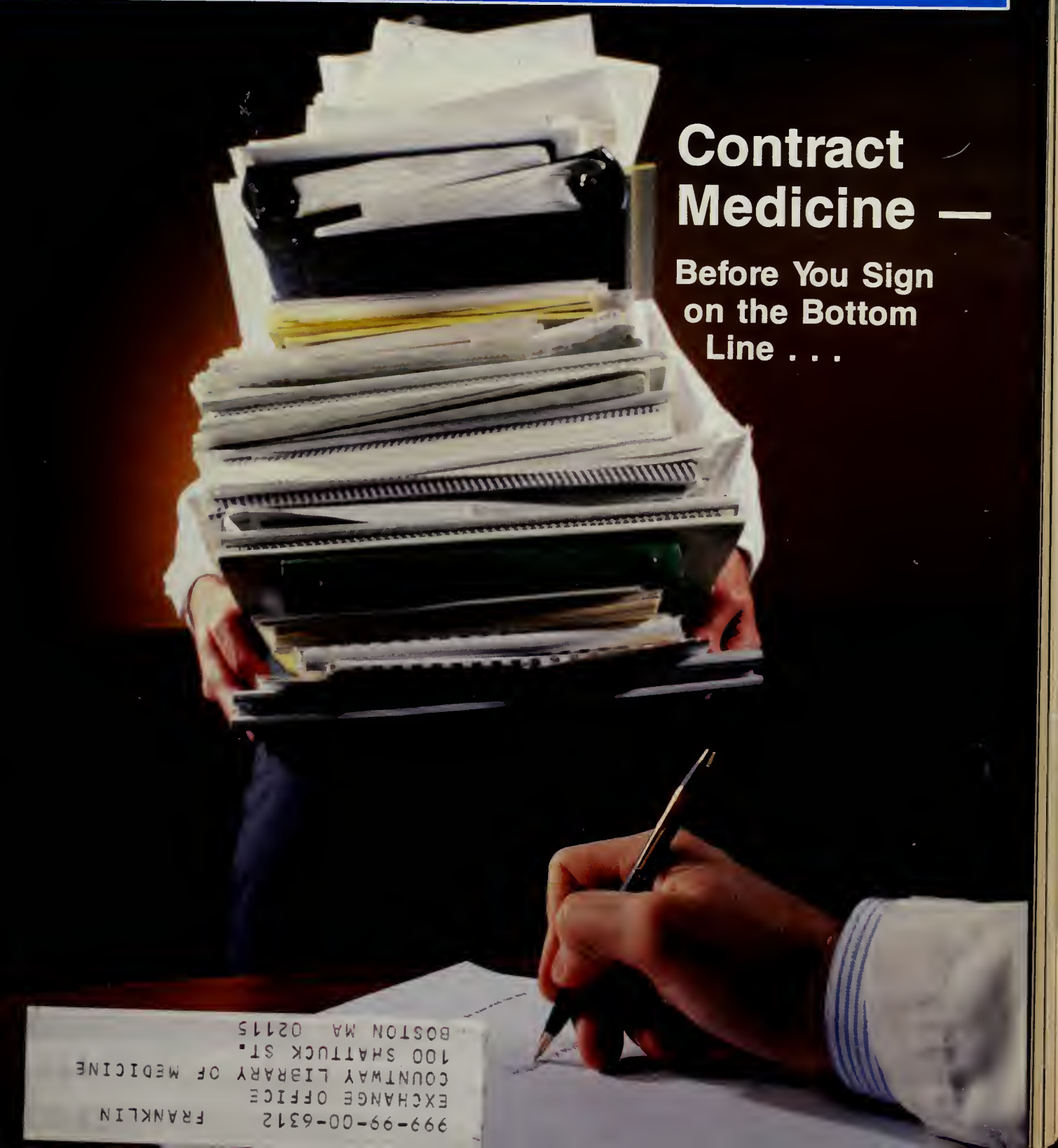
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OHIO Medicine

JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

VOL. 83, NO. 2

FEBRUARY 1987



Contract Medicine —

Before You Sign on the Bottom Line . . .

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nights of sleep...

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sleep that satisfies

Please see adjacent page for references and summary of product information.

References: 1. Kales J, *et al. Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. 2. Kales A, *et al: Clin Pharmacol Ther* 18:356-363, Sep 1975. 3. Kales A, *et al. Clin Pharmacol Ther* 19:576-583, May 1976. 4. Kales A, *et al. Clin Pharmacol Ther* 32:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR. *J Am Geriatr Soc* 27:541-546, Dec 1979. 6. Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. 7. Kales A, Kales JD. *J Clin Psychopharmacol* 3:140-150, Apr 1983. 8. Tennant FS, *et al.* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. 9. Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther* 21:355-361, Mar 1977.

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sleep that satisfies



15-mg/30-mg capsules

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. In patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.
Contraindications: Known hypersensitivity to flurazepam HCl, pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.
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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, fatal and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.
Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage. 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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FROM THE EDITOR

Tax time . . . where did all the deductions go?

If you're not already hotly embroiled in computing your new taxes, you soon will be. This year, however, we thought we'd lend you a hand.

Now don't get us wrong — we're not about to show up at your office with our sleeves rolled up and a handful of IRS forms to help you fill out. But if you read John Sestina's article "What Now After Tax Reform?" in this issue, you're bound to find answers to questions that have been plaguing mankind for the better part of two months now. Sestina is a vice president of SMB Financial Planning, a subsidiary of PICO, so you can bet his article will contain all the facts and latest information, designed especially for you, the physician. It may not be everything you ever wanted to know about the new tax laws — but it should give you some much needed help in filling out your 1986 forms. Good reading . . . and good luck!

Associate Editor Susan Porter has written an informative article about contract medicine for all of you who may be considering offers from HMOs, IPAs, PPOs and other types of alternative care systems. Our last piece on contract medicine — the do's and don'ts and what-to-look-for — ran a couple of years ago — but requests for help in this area continue to come in to the OSMA, so we felt it was time to update our information and share it with you. We hope it helps you in any contract negotiations you may be presently involved with.

How's your handwriting? Doctors have always had a rather nasty reputation when it comes to name-signing and prescription-writing — but one Ravenna physician uses a person's handwriting to learn more about the person's character — the strong points and weak points inherent in us all. Rogelio Marcial, MD, is a bona fide handwriting expert, and Assistant Editor Deborah Athy explores how handwriting analysis is done for our "Out of Practice" column. You may want to see how *your* handwriting compares.

This month's "Ohio Medi-scene" features stories on nursing home care, eating disorders, and how to improve your patient relations.

And next month, we will take a look at a new up-and-coming specialty, Adolescent Medicine.

So take a brief break from your taxes, and enjoy this month's Journal. Who knows? You may even find a deduction you might have otherwise missed . . .

Karen S. Edwards

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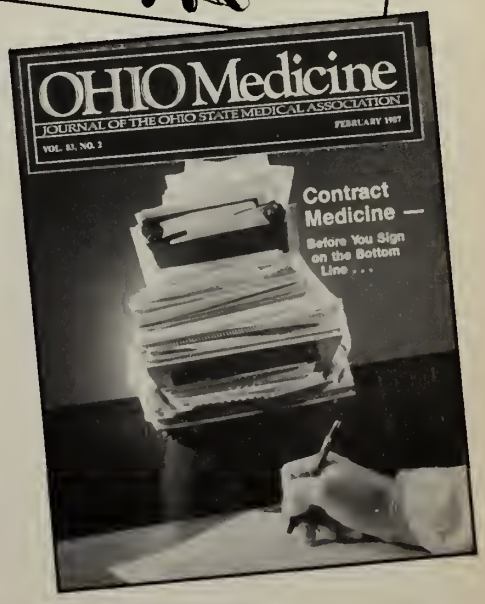


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JOURNAL COVER:

This month's cover was photographed by freelance artist-photographer Larry Hamill.

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"Corporatization" of Medicine



Just as in the early 1900s when the industrial revolution took over in America, we as physicians have seen, over the last 10 years, a "corporatization" of medicine. This "corporatization" has meant the influx of lay people who have formed health care corporations, HMOs, and other types of health delivery systems which have put decisions not in the hands of physicians, but in the hands of non-physicians whose decisions sometimes are based only on the bottom line. We have seen entrepreneurship force itself onto health care because health care has become, as we all know, a multi-billion dollar affair and a very ripe apple for the picking.

The beginning of this change in health care delivery actually started in the days when we first became involved with insurance for medical care and the third party payers became more and more involved. The moment that we gave up part of our patient-physician relationship to a third party payer, we put ourselves under the control of those people who hold the purse strings. Not all of this has been bad, because certainly there are people who cannot afford health care without insurance. Our patients have received care which otherwise they may not have been able to receive, and physicans have received payments that they might not have otherwise received if there were no third party plans; but, at the same time, the physician started to give up control of the patient's care.

Under the guise of cost-saving, we have seen the introduction of such policies as pre-admission notification, pre-admission certification, expanding use of outpatient facilities, prescribed length of stay and many other factors which have centered on the cost and not necessarily on the quality of care. I think that we as physicians have always been interested in the cost of medical care, but our prime concern has been that our patients receive quality care.

There is no question that alternate health care delivery systems have been necessary, and many are viable and are concerned primarily with quality of care along with proper utilization. Many of our physican members have contracted with these systems, and some with several systems. The physician has the MD degree and no corporation can manufacture the MD degree. What the physician does in signing contracts is done willingly and should be done after careful thought and consideration.

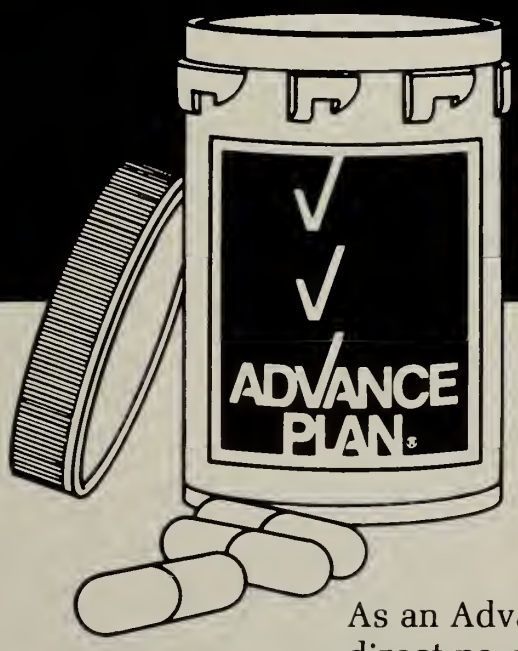
The article in this particular month's issue deals with physician contracts and tries to give some pointers on what to look for in contracts and how to make your decision as to whether to sign or not sign. Too often physicians have sent their contracts to their accountants and have allowed the accountant to make the decision. I do not personally believe that the accountant can make this decision, because all he is looking at is the bottom line — how it adds up as far as figures are concerned — and he misses the real point of why a physician is a physician. Oftentimes, accountants never can understand the physician's dedication in taking care of patients and the innate philosophy of the physician: that providing excellent health care to patients is the primary purpose and that the monetary issue is secondary. This is something that is unique to physicians and to the medical profession, and it is difficult for those outside our profession to understand, particularly those who continuously deal with assets and liabilities.

Physicians have chosen to join health care delivery systems for various reasons. Some do so because it gives them a different life style as far as having more regulated hours and the ability to practice within a group with group consultations and set goals in mind. These are all positive reasons for being involved in corporate medicine.

I think the loyalty of physicians though should be primarily to their profession, and this should be through their establishments of organized medicine: their local societies, state society and national society. I think that we all have to remember that we are physicians first, specialists second, and that whatever group we belong to, as far as an alternative delivery system, should not compromise our principles and philosophies as physicians who care about our patients, who listen to our patients, and who want to deliver the best quality of care to our patients in the best setting, with the best utilization, and in the most cost-effective manner.

John E. Albers, MD
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The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of Ohio Medicine or the Ohio State Medical Association.

The Right to Know

By Howard A. Steiner, MD

Years of medical practice have altered the attitude of the patient with respect to the physician and the advice or treatment he or she would receive. No longer the day of acceptance without questioning the advice, treatment, prescription, etc., given by the family physician. The doctor was a "healer," respected and accepted for his or her ability and status — and not to be questioned.

Now, medical knowledge, leaping ahead by giant steps, has taken on a new role. Increased specialization, instrumentation, diagnostic acumen, and improved and new approaches in medical treatment and surgery have given the medical world a new appearance. But, more significant, the interest and education of the general public is now accepted, promulgated and sought. Years ago, one might obtain a book — sparingly available to the public, in which illnesses and symptoms and essentials for treatment and possible cures were discussed. Today, *Readers Digest, Prevention,* and many other journals and periodicals, including our daily newspapers and special TV cable medical programs, are exposing our public to real medical facts and education. This is good, and long overdue.

The result is a more discerning, interested and questioning patient. Not that the patient is in quest of a second or even a third opinion, but now the patient is prone to enter into more intelligent conversation with the doctor, and obtain information as to what might be expected diagnostically and therapeutically. This is fine, and as it should be. This new reality has even assumed new legal ramifications, and now the

Now the patient is prone to enter into more intelligent conversation with the doctor . . . this is fine, and as it should be.

"Informed Consent Form," which not so many years ago the doctor had difficulty in composing, is now a must for many procedures. Its legal implications have undergone clarification. This has involved the legal profession which has now entered into this new medical arena.

Speaking of the legal profession, whoever paid much attention to "malpractice policies or insurance" years ago? If a doctor carried such insurance years ago, it was done on a voluntary basis, and frequently regarded as an unnecessary expense. How times have changed — primarily because of the patient's "right to know" the facts and — with hesitation — I add the interest of the legal profession as well. Now, it is becoming commonplace for a physician to not only have to prove he or she carries malpractice insurance, but, in many institutions, a specified minimal amount of insurance must be carried if he or she is to have or maintain privileges there.

The years have made a change. One could discuss in detail the many new medical specialties, the new medical and surgical procedures resulting in a healthier, longer-living and more productive society. It is our people who are the center of this magnificent improving environment, and because of our attitude, our patients should be — and are becoming — more concerned about their health and ways to improve it. This is proper and the future is promising. Our patients, our people, are now realizing "the right to know."

Howard A. Steiner, MD, is a staff radiologist at the VA Medical Center, Wade Park Division in Cleveland.

OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians.

Edited by Deborah Athy

Doctors fear black market AZT

Requests for azidothymidine, or AZT — the experimental drug which has had dramatic results in treating some AIDS patients — have become so great that doctors are now fearful a black market for the treatment may soon develop.

It wouldn't take much, they say, for a chemist to copy the formula and sell it to desperate patients on the streets, or across the border in Mexico. And, because AZT is the first promising drug against AIDS, few have any doubts that there will be plenty of buyers.

The government, however, has attempted to counter the drug's move to the black market by instituting strict controls on its distribution. Michael Para, MD, one of several Columbus physicians who has applied for the drug for his AIDS patients, was recently quoted in the local newspaper as joking about having to get "my decoder ring from the government" before getting the drug.

Part of the problem of AZT finding its way to the black market is the fact that the drug is not intended for every AIDS patient. Only those who have survived a rare form of pneumonia are considered "qualified" to receive it. If a patient has another infection, or liver disease, or certain other ailments, the drug may not be as safe.

Even for qualified patients, however, AZT is not without its toxicity, doctors note. It can depress the bone marrow, or cause anemia, liver inflammation or kidney problems. For this reason, they say AZT should be taken only under close medical supervision.

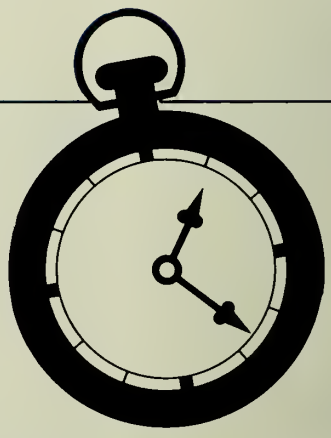
Shaping up today's youths

A former gymnast and her husband, a gymnastics coach at the University of Illinois, are attempting to shake the lethargy out of latchkey kids and other youngsters who, largely because of circumstance, sit in front of the television set each afternoon, instead of involving themselves in healthy, physical play.

The Hayasakis have begun to operate "Sportastiks Gymnastics Centers" in their home state — places where children from 1 to 18 can go to receive gymnastic instruction as well as the freedom to experience all types of physical exercise.

Three programs have been designed by the Hayasakis to meet the needs of the young participants — one for Olympic hopefuls; one for children who simply want good physical fitness; and one for youngsters who may suffer from a specific disability or handicap — such as hearing loss, asthma, even heart trouble.

In any of the three programs, the goal is the same — getting fit while having fun. After all, why should Mom and Dad, with their expensive health clubs, have all the fun?



Bright lights may reset biological clocks

Those who work shift rotations or frequently travel across multiple time zones may soon be in luck.

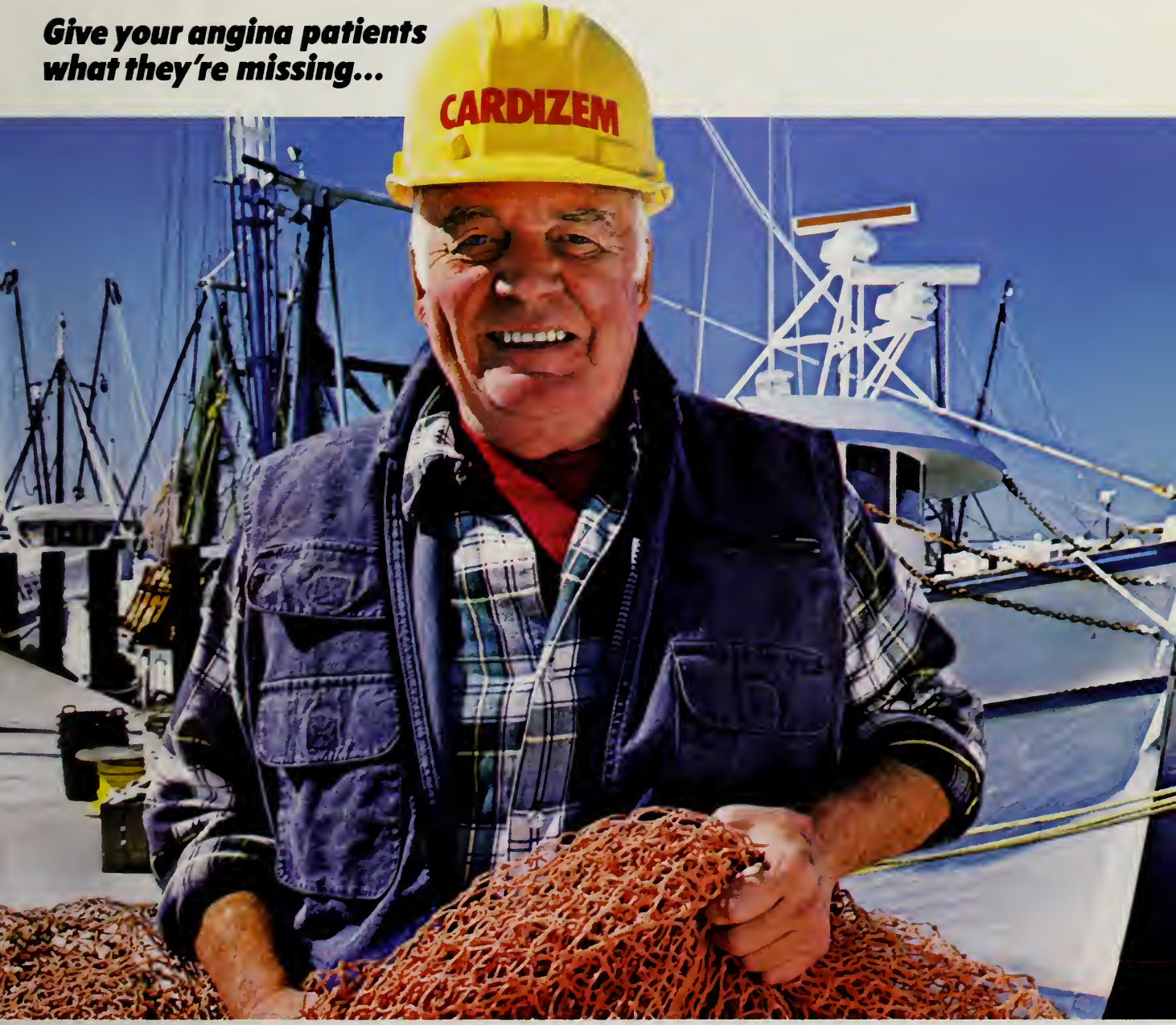
A team of Harvard scientists have learned that our biological clocks — those inner timepieces which control our daily physical, behavioral and cognitive functions — can be artificially reset by exposure to bright light.

Tests conducted on an elderly woman, who was exposed to bright light for four hours on seven consecutive evenings (while maintaining her regular sleep-wake schedule and social contacts), resulted in a six-hour delay of her circadian pacemaker.

Although the investigators had theorized in advance that bright light in the evening might reset the patient's biological clock, they say they were surprised at the magnitude, rapidity and stability of the shift.

Additional studies will be needed to show whether critically timed exposure to bright light will be of value in treating sleep problems related to jet lag and shift work, say the Boston investigators, but, so far, the "bright light" theory looks promising.

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CONTRAINDICATIONS
CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS
General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/posthatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 7/86

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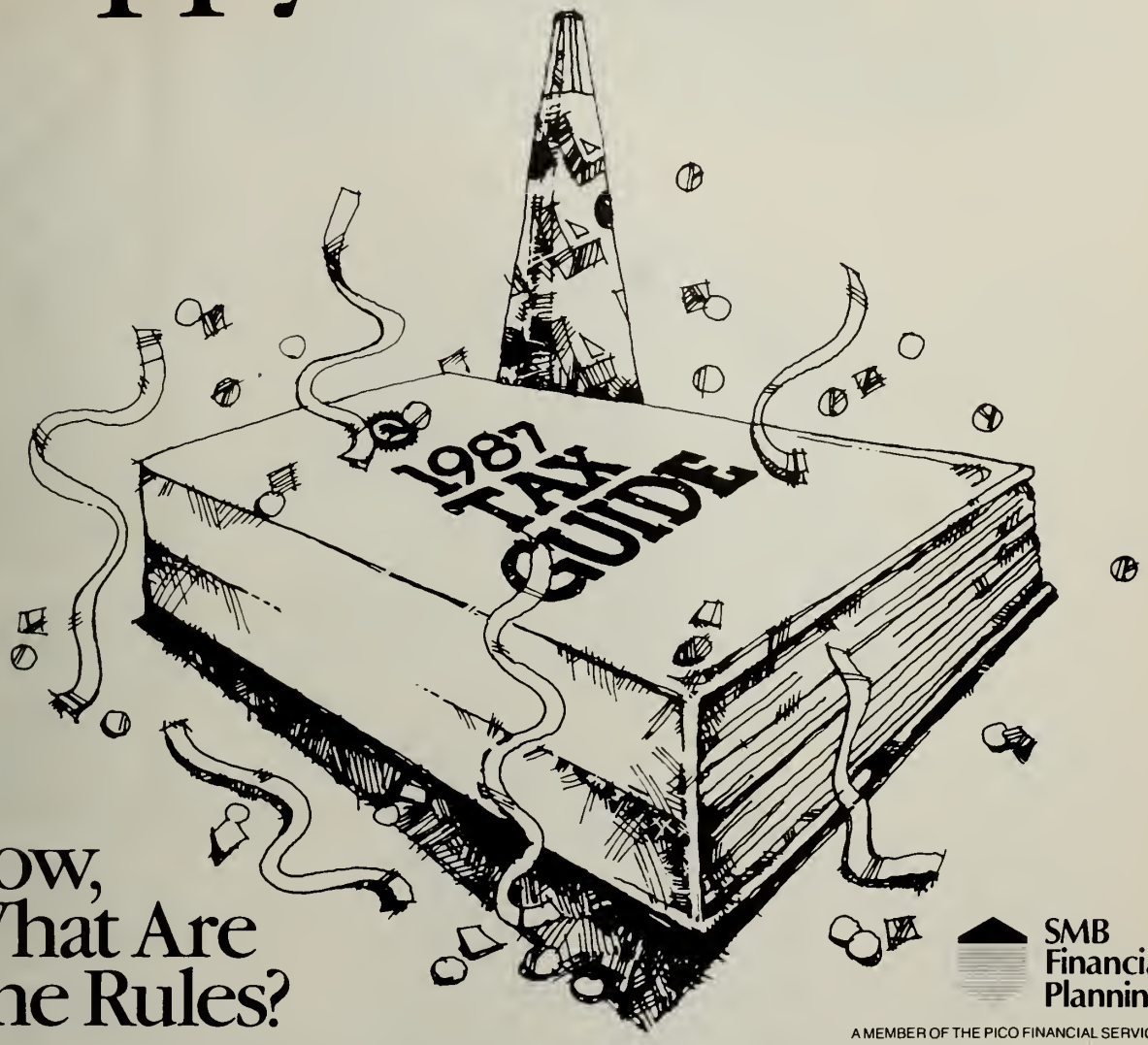
References: ***1.*** *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983, 106(6): 1341-1347.* ***2.*** *Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984,24(Dec): 150-159.* ***3.*** *Johnstone DL, Lesoway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985,55:680-687.* ***4.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap. 39.* ***5.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.*

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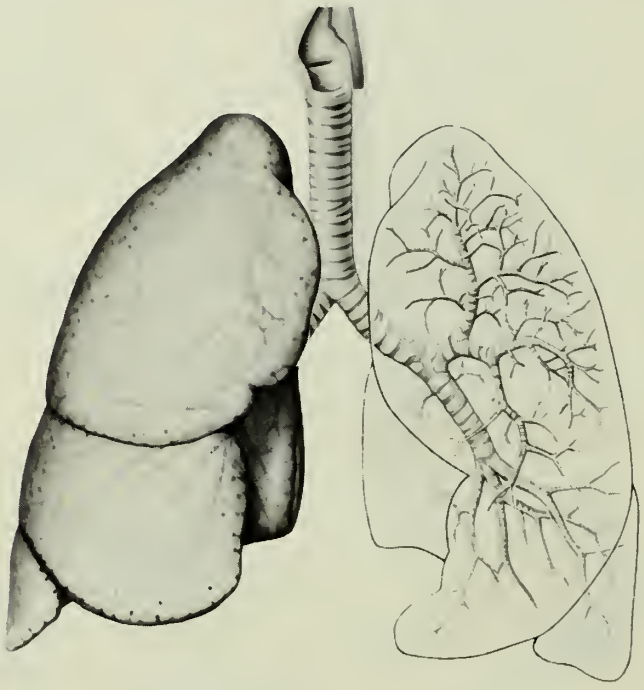
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Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

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Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%, usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

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- Slight elevations in hepatic enzymes
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
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Nursing home care . . . treating the eating disorder patient . . . marketing your practice . . .

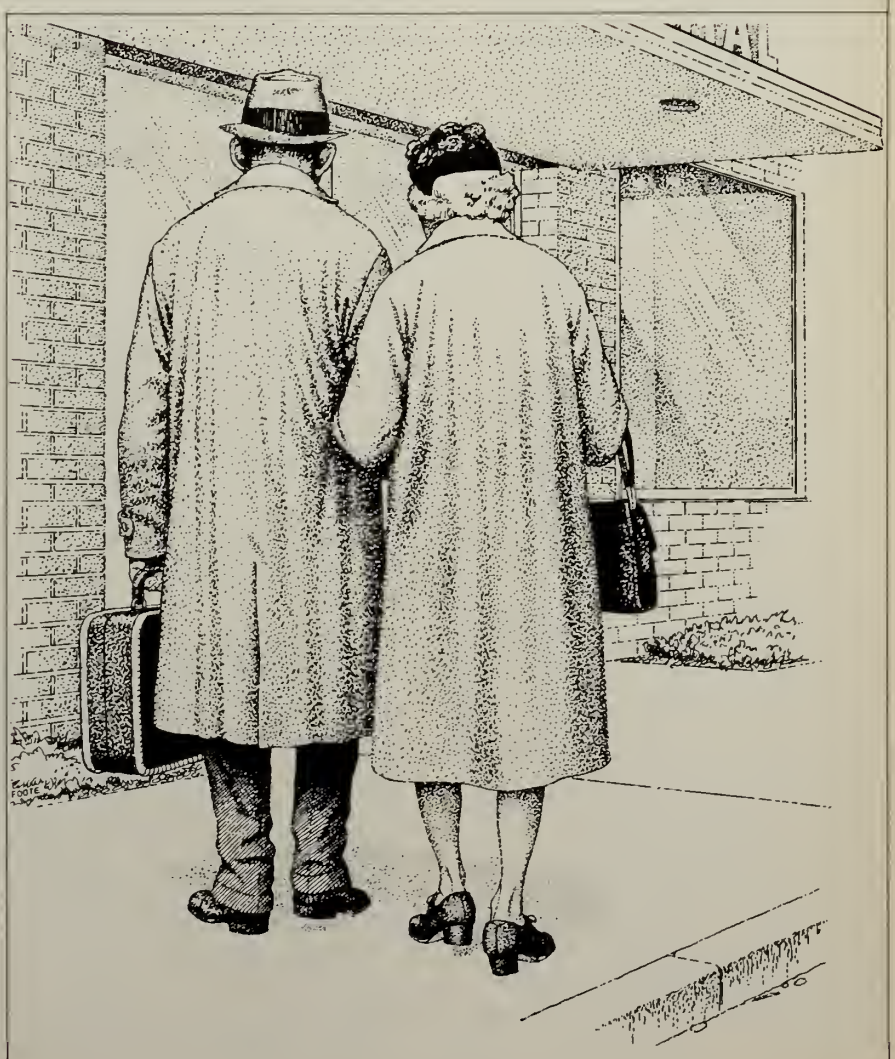
Nursing home care — how good is it?

Whether or not you have patients in nursing homes, you have doubtlessly heard stories about the type of inadequate care delivered there. Are the stories justified? And, if they are, is there anything the medical profession can do to improve the quality of care in these facilities?

These are the questions that recently brought members of the OSMA's Committee on Geriatric Medicine together with key leaders in nursing home care. Jointly, they discussed some of the problems that are occurring in this industry which now affect approximately 90,000 patients who are being cared for in 1200 nursing homes around the state — a figure which is expected to double in the next 10 to 20 years.

The prospective payment system is being blamed for much of the overcrowding, as hospital patients are being dismissed earlier and earlier — and usually straight into these facilities.

"The nursing home has become like a small acute-care hospital," says Roy L. Donnerberg, MD, Chairman of the Geriatrics Committee, who also noted that nursing homes are beginning to see more and more patients with



OHIO MEDI-SCENE

Nursing home care . . . *continued*

behavior problems.

"In addition to dementia patients, nursing homes are accumulating those types of people who never really fit into society," says Dr. Donnerberg. Suddenly, doctors, as well as the nursing home staff, are forced to deal with patients they have not been trained to deal with.

"The psychiatric care which is desperately needed is not readily available in nursing homes, so we are faced with the dilemma of "what do we do?," says Dr. Donnerberg.

The state does provide training centers for nursing home personnel, says Joya Neff, a nurse who is a past nursing home inspector for the Ohio Department of Health. They were established in the 1970s to provide in-service programs for nurses, activity directors, nutritionists and aides — "but they are under-utilized," says Neff. "Nobody knows they're there."

Yet something is needed to pull this group together, she claims.

"We need to make a collaborative effort to improve the nursing home staff since they have no professional or trade association which brings them together," Neff says.

And, according to others who participated in the round-table discussion, the staff "makes or breaks" a nursing home.

"Aides are the crux of any nursing home," says Charlotte Miller, who is in the Department of Geriatrics at Case Western Reserve University. "They are the ones who provide the daily hands-on care."

Yet they are the ones who are most often underpaid and ignored.

"They need our support," she says.

Albert Tsai, MD, a Ravenna physician who has approximately 300 of his patients in nursing homes and is the medical director of both profit and not-for-profit nursing homes, is well aware of the injustices in the system.

"You do need to pay to keep good aides around," he says — but he also speaks of the difficulties that regulation brings about.

"The nursing home industry is more regulated than anything else," he says, adding that is where most of the problems lie.

"But regulation talk is tough because it's a balancing act," says Karen Crosman of the Ohio Department of Aging. "Some regulation is needed to ensure quality care."

The ODA's nursing home ombudsman Roland Hornbostel echoes her sentiments.

"The major area of concern we have is the quality of care provided."

"Eighty percent — four-fifths — of all nursing home care is provided by nurses aides, and yet a fry cook at McDonalds makes more money . . ."

He agrees that much of this care is provided by a staff that's "poorly trained, poorly paid and poorly motivated."

"Eighty percent — four fifths — of all nursing home care is provided by nurses aides, and yet a fry cook at McDonalds makes more money," says Hornbostel.

The Ohio Department of Health has implemented a long-term care survey in nursing homes to ensure that care is meeting federal standards, yet he says that clearer, more logical and understandable standards are needed since they are, obviously, here to stay.

"President Reagan did make a move to de-regulate nursing homes, but it was immediately halted by Congress," says Hornbostel.

The federal government is taking a new look at the way nursing homes are being regulated, however, so there may be some changes occurring in the future.

"But only if we tie into the political process," says Kenneth A. Frederick, MD, a Cincinnati physician and Vice Chairman of the Committee on Geriatric Medicine. Dr. Frederick believes that, in order to effectively change the system, "we need to tell the public that their health care dollars are being spent the wrong way. That's what they'll react to. They're through listening to speeches about their health-care needs."

He tells the story about a nursing home in Cincinnati,

staffed, in part, by family practice residents from the University of Cincinnati.

"These kids really want to put the elderly back on second base, and they're prescribing procedures that would put them there. But the surveyor comes along and tells them they can't do that — they can't make the elderly better because they are turning the nursing home into a junior hospital and it's only licensed as a long-term care facility.

"What the government is saying, then, is that it is perfectly willing to have these patients sent back to acute-care hospitals — at higher prices — than to pay to keep them well in the first place."

That's the kind of message Dr. Frederick would like the public to hear.

Committee member Ross R. Black, MD, an Akron physician, shares another story about nursing homes and their financial inefficiencies.

"One surveyor came up to a nursing home administrator and warned him about patients who were wandering outside, unnoticed," he says.

Instead of alerting the staff, an elaborate electronic system was installed so that, in order to leave the home, you had to punch in a code — which was always the date of the current year.

"They're assuming that if you know what year it is, you're safe enough to go outside."

Robert E. Norman, MD, another Akron physician and member of the committee, tells how each word written in a report must be couched in careful language — "since you are at the mercy of the reviewer and his or her whims."

"Nursing homes need one set of rules," he adds. "And people need to know these are the rules."

Whole industries now exist which show nursing home administrators how to make the system work in their facility. There are consultants you can hire who will tell you the right words to use in your reports," says Dr. Frederick.

But the system is not without its idealists, says Watson D. Parker, Jr., MD, of Dayton.

"There are people who want to help. Geriatrics is a hot area for idealists right now, but as more and more people age, the idealists will begin to burn out. Now is the time to fix what's wrong with the system. There are identifiable problems — we need to find them and start fixing them.

"It's like researching Alzheimer's disease," Dr. Parker sums up. "It may not help the people with problems today — but it will help those in the future." — *Karen S. Edwards*



The physician's role in treating an eating disorder patient

The team approach of treating eating disorder patients — physician, psychiatrist, dietician, etc. working together — has been well-advocated, according to Michael Yaffe, MD, an internist in the Inpatient Medical Psychiatric Unit at Riverside Hospital in Columbus. The physician's responsibility as part of this team is to maintain a classic patient/physician relationship, he says.

Speaking recently at the National Conference on Eating Disorders in Columbus, Dr. Yaffe emphasized that the initial diagnosis of the patient is very important and should outline what physical problems are present because of the eating disorder. In addition, a careful medical history is essential.

"The first and most important responsibility is that we (physicians) don't overlook another important organic disease." For example, if one of your female patients has stopped menstruating and has started vomiting in the mornings, you must rule out the possibility of pregnancy, he explains.

Once the initial diagnosis has been assessed, the physician should continue to participate in the patient's recovery. Be aware that some patients may try to put the physician through "a workout that a non-psychiatrist is not prepared to deal with," Dr. Yaffe says. For example, patients may try to convince their physician to prescribe medication although they are already receiving medication from a psychiatrist.

Working with eating disorder patients can be both challenging and exhausting, Dr. Yaffe sums up.

OHIO MEDI-SCENE

Treating eating disorder patients . . . *continued*

Keep in mind, he adds, that rewards do not come easily.

The following are some key areas to look at in your evaluation of the eating disorder patient.

**Amenorrhea.* Female anorexics often stop menstruating. Determine, first of all, whether the patient has a normal menstruation history and rule out pregnancy. Amenorrhea can be treated pharmacologically — with the Pill or estrogen — or nutritionally, i.e., by increasing body weight to the point where the patient naturally begins to have periods. Dr. Yaffe opts for the nutritional route when possible.

**Gastrointestinal/Bowel.* Many anorexics have abnormal bowel cycles (once every two to three weeks, for example) because of their sparse, low fiber diets. Consequently, these patients often experience constipation, which may eventually trigger laxative abuse. Bulemic patients turn to laxative abuse to even out their binge-eating episodes. In any case, it is very difficult to wean some of these patients from the use of laxatives. The first step toward normalcy is in the direction of a healthy diet. Dr. Yaffe recommends a high fiber diet which includes two fruits and two vegetables per day, along with a fiber supplement. Be forewarned though, he says, that most patients soon discover that these fiber supplements contain calories. Try to make them understand that calories are absorbed *before* they reach the bowel. If a patient absolutely needs some type of bowel assistance, Dr. Yaffe recommends milk of magnesia once a week. Interestingly, some anorexics turn to laxatives as a result of counseling. That is, they pick up on questions such as, "Have you ever taken laxatives to lose weight?" From this type of question they surmise that losing weight through laxatives is a possibility. For this reason, Dr. Yaffe says to watch for signs of new eating disorder behaviors.

**Cardiovascular.* Much medical literature has been penned about the cardiovascular effects of anorexia. Singer Karen Carpenter's fatal brush with the cardiac toxin ipectac is one incident which prompted increased news coverage in this area. Other cardiovascular conditions associated with anorexia include arrhythmia and mitral valve prolapse. There is some question whether mitral valve prolapse is acquired because of eating disorders or whether individuals with mitral valve prolapse could be predisposed to eating disorders. A key concern to physicians may be how often to perform an electrocardiogram? For all practical purposes, says Dr. Yaffe, an EKG is in order if the patient is at high-risk — if he or she takes antidepressants, continues to lose weight, or if other clinical grounds are present, such as palpations, panic symptoms and dizziness.

Kidney. Many eating disorder patients become dehydrated, which may cause a severe malabsorption phase and renal concentration. Special attention should be given to fluid intake. Electrolyte abnormalities and low potassium may result. (However, Dr. Yaffe says in his experience about 85% of habitual vomiters have normal potassium levels.)

Edema. If the patient is dehydrated and the kidney is having difficulty concentrating water, edema (swelling) may result. Swelling ankles, etc., could be an extremely frightening experience for a person who dreads the appearance of fat. Try to make the patient understand that the condition is only temporary.

Vitamin/Mineral Deficiencies. Take thorough vitamin/mineral histories. Pay attention to vitamin D and calcium intake (lack of which may lead to osteoporosis). The patient should take a multiple vitamin or calcium supplement if intake is low. Low grade anemia is also common because anorexics eat little red meat and other iron-rich foods. An iron supplement may be needed. Pay attention to potassium levels as well.

Thyroid. The thyroid may work in an adaptive way to save calories, so there may be difficulty differentiating between a thyroid condition and an eating disorder condition, Dr. Yaffe says.

Mouth/Teeth. Bulimics bring large amounts of acid into their mouths when vomiting, which can lead to gum disease and teeth decay. Patients should be urged to brush with baking soda or with an alkaline toothpaste. In addition, Dr. Yaffe says physicians should urge their patients to confide in their dentists about their condition. — *Deborah Athy*

Marketing your practice — internally

Who answers your phone during lunch hours — your staff or your answering service? Do you provide your patients with cloth gowns or paper? Where do you hang your diploma?

Believe it or not, your response to these questions may mean the difference between a healthy, thriving practice with plenty of paying patients and a practice that seems to be hitting the skids.

"Marketing a practice is really an internal effort," says George Conomikes, of Conomikes Associates, Inc., a practice management firm which handles between 120 and 125 consultations a year. The OSMA recently sponsored six workshops on "Marketing your Practice," presented by Conomikes Associates at different locations around the state.

"Internal marketing is dealing with patients so well that they will come back again and again and bring people they know with them," he says.

Statistics reveal that a happy patient will usually tell one to four of his or her friends about your practice — but beware the patient you may have made angry, cautions Conomikes.

"These people develop a grudge, and they don't mind talking about it," he says — "sometimes for as long as nine years."

Internal marketing, however, is one way to assure that your patients stay happy. "It's in your control."

Before actually taking steps to improve your practice, however, Conomikes urges physicians to develop a profile of the type of patient they want in their practice.

"Take what you consider to be your most desirable patient, usually someone middle-class to upper middle-class; factor in your most profitable services, and you have your 'best patient scenario.' "

These are the patients for whom you should be shaping your practice, says Conomikes.

How do you shape your practice to draw the best patients? By accommodating your hours, location, even office furniture to *their* likes and dislikes.

For example, he suggests that you stagger your staff's lunch hours so there is always someone on hand to answer telephone calls.

"Many of your best patients will be working men and women who schedule appointments on their lunch hour — not just for convenience, but for privacy.

"If your office is closed during lunch and an answering service takes the call, it means two things to the patient — you are neither available nor accessible, and they'll call someone else," says Conomikes.

Your best patients are intelligent, he adds. They are concerned enough about themselves and their family to have checked around. They know who else is out there — "they go to the phone with two or three names in hand," and if they think you are not accessible, they will move on to the next name on their list.



Conomikes also cautions physicians to beware of busy phones.

"Adding lines is not a solution," he says. Instead, he recommends that you designate functions for each of your existing lines, so that instead of seven numbers that serve all purposes, you have two lines to receive incoming calls from patients; a direct line to the hospital; a private line for the doctor; one or two lines to handle business calls (which, incidentally, should be the number printed on your bill); and perhaps a personal line for employees, especially if you have eight or more.

In this way, explains Conomikes, the receptionist can concentrate on patients and hospital lines; your billing manager on the business-lines; and so on.

"If you are going to use an answering device, then use it on the billing lines — not the patient lines," he says.

"If your office is closed during lunch and an answering service takes the call, it means two things to the patient — you are neither available nor accessible, and they'll call someone else."

The right attitude is also important when answering phones.

Remember, most people who call your office do not really want to be calling at all," he says. Many people will put off calling their doctor until the last possible moment, or until they've reached a point where they simply can't take the pain or the illness or the

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Marketing your practice — internally . . . *continued*

problem any longer.

"When people call in, they want immediate service, not something that's two weeks down the road," says Conomikes. That means scheduling appointments for patients as soon as possible — "and new patients should be worked in in two to three days," he adds.

To maximize your "best patient scenario," Conomikes believes it's necessary now to extend office hours into the evening, or hold Saturday office hours.

"A doctor we know began Sunday hours, and built up an affluent clientele," says Conomikes. Why? "Because busy executives and attorneys work evenings and Saturdays, too," he answers.

Before making any changes, however, Conomikes suggests you survey your patients to learn what hours they would be happy with, then plan your practice hours accordingly.

"During the 1970s, doctors could afford to run their practices for themselves, but this is the '80s — an extremely personalized generation, as well as a competitive one. The successful doctors are going to be those who run their practices for their patients instead of themselves."

He suggests doctors consider taking two half-days off, instead of a whole one — to assure "daily availability" . . . "and be prepared for more and more doctor interviews, where patients meet with you prior to scheduling an appointment for a get-acquainted visit."

What else will the successful doctor of the future do? Here are some additional "internal marketing" tips, recommended by Conomikes:

*Check your reception area. It should have plenty of chairs with arms (especially for elderly patients), and cloth instead of vinyl seats. The reception area is also a good place to hang your diploma, if you don't use your office much for consultations . . . and think about adding family pictures, an interesting collection . . . some vintage magazines like "Life" or "Look." Skip the coffee machine, though, says Conomikes. "It turns your receptionist into a waitress, and she has better things to do with her time — like answering your phone and greeting your patients."

*If possible, place scales in the examining room "so the nurse doesn't shout out a patient's weight in front of everyone."

*"Patients love cloth gowns," says Conomikes, who says such "patient-pleasers" are not only worth the small investment to purchase them, but the additional money needed to keep them freshly laundered.

*Consider hanging the doors to your examining room backward, to protect the patient's privacy, says Conomikes. "They'll open the wrong way, and so screen the patient from those who may be standing in the hall."

*Patient hand-outs are essential for hospital visits, and you or your office manager or nurse should go over instructions with the patient. "Never hand out preoperative instructions until the patient has committed to surgery," warns Conomikes, "and don't give them post-operative instruction until after they have had the surgery."

*The doctor should always introduce himself or herself to the patient, use the patient's last name with "Mr.," "Mrs." or "Ms.," and make eye contact, "instead of staring at the chart."

*Finally, Conomikes suggests you and your staff keep an ear open and listen for patient complaints. "There is no such thing as an idle complaint," says Conomikes. Remember, he adds, if a patient is unhappy — and you or your staff are not doing anything about it, that complaint *could* be around to haunt you and your practice for the next nine years. — *Karen S. Edwards*

"During the '70s, doctors could afford to run their practices for themselves, but this is the '80s — an extremely personalized generation as well as a competitive one. The successful practices will be ones run for patients."

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Contract Medicine — Before You Sign on the Bottom Line

By Susan Porter

Four years ago this month, a little-known entity called a Preferred Provider Organization (PPO) appeared in Cleveland, where area doctors for the first time were offered the chance to participate in an alternative delivery health care system right in their own offices. Unlike the handful of Health Maintenance Organizations (HMOs) operating in the state at that time which hired physicians as full-time staff members, the PPO concept allowed doctors to retain their traditional fee-for-service practices. Yet at the same time, it gave them the opportunity to compete more effectively with the staff-model HMOs that were moving into their areas.

Since that time, physicians throughout the state of Ohio have been made numerous offers to participate in a variety of forms of alternative delivery and financing mechanisms, including PPOs, HMOs and Independent Practice Associations (IPAs) — still another HMO variation. At the present time, there are 37 PPOs operating in the state, along with 45 IPAs and other HMO models.

And with the current medical-economic climate, "Ohio is ripe for more," says D. Brent Mulgrew, Esq., managing director and counsel of the Ohio State Medical Association. "Ohio law is pretty liberal as far as organizing alternative delivery systems is concerned," says Mulgrew, adding Ohio is already among the top five states in the nation in the number of plans operating here. Only California with some 432 alternative delivery systems in operation significantly outranks Ohio in the number of these plans.

Thus, it is not unusual for a physician today to be courted by any number of business entities — all of whom hope to extract a legal commitment from doctors to provide medical services, in exchange for certain promises, such as a larger patient base or prompter payment for services. Almost always, these trade-offs come in the form of written agreements or contracts which, if not examined carefully, could bind the physician to a host of conditions and responsibilities which may not be to the best interest of his/her practice or patients.

"We have seen some frightening cases," says Elizabeth A. Snelson, manager of the California Medical Association's Department of Contract Evaluation/Negotiation Services and one of two attorneys who reviews some 100 contracts submitted by physicians in that

"Physicians are often subject to marketing schemes and other ploys which encourage them to sign a contract without really understanding what they're getting into."

state each month. Not only do some of these contracts jeopardize the financial well-being of the medical practice — some are downright illegal and could result in a revocation of a license or even charges of fraud should a physician choose to sign them, says Snelson.

"Physicians are often subject to marketing schemes and other ploys which encourage them to sign a contract without really understanding what they're getting into," says Snelson. However, it's not always a matter of intentional deception; rather, those forming the business entity may not be aware of the numerous restrictions and regulations governing the practice of medicine.

"There are special laws that apply to physicians and no one else," Snelson says, pointing out that antitrust regulations must also be taken into consideration when physicians join together through contracting. Those business entities or physicians inexperienced in this area may unwittingly include or approve provisions for fee-splitting, price setting or excluding competition without realizing the illegalities of these practices.

Still, ignorance of the law is no excuse and physicians who sign such contracts may find themselves breaking the law while attempting to conform with the provisions of the contract. Thus it is critical that before signing any type of contract or business agreement, "You know exactly what you are signing and whom you are dealing with," Snelson says. "Just because a contract is typeset, doesn't mean it's OK."

Jerry Clousson, president of Physician Support Services, Inc., a law firm which offers contracting advice to physicians throughout the country through the American Society of Internal Medicine's new subsidiary Medical Advocacy Services, Inc., agrees. "You can't write a contract that will handle every contingency," Clousson points out. "So you have to be able to trust the people you are dealing with." Yet too often physicians have no idea exactly who is behind the proposal, he says. "It may simply be an entrepreneur who is trying to build some capital," he says.

One problem with many newly-forming alternative delivery systems is that "many of these organizations have a limited capital base or financial resources," says Mulgrew. Therefore, "the physician's payment withhold becomes the foundation of the operating funds, rather than a holding fund available for year-end payback."

In some unfortunate instances, withholds may be increased from 20% to 40% simply to keep the operation going, Mulgrew continues. In other cases physicians' fees may be completely withheld until all other bills are paid, so that "physicians carry most if not all of the financial risks associated with the plan," Mulgrew explains.

Tracking the reputation and financial stability of the larger for-profit health care systems which now offer blanket contracts to physicians throughout the country is relatively easy, Clousson notes. However, both he and Mulgrew are now observing that more and more small, local entities — often limited to a single hospital or employer — are coming into the picture — many of which have no track record or financial history.

Another major problem Clousson has identified through his work is that often contracts presented to physicians are incomplete. "They may seem complete on the face," he says, "but the contract may refer to or bind the physician to other documents which are not attached, such as utilization review systems, grievance procedures, compensation schedules, etc." By signing the contract, Clousson says, the physician commits himself or herself to the entire package — regardless of whether or not he or she has seen all of it.

In addition, contracts often contain blank spaces, or they may have gaps, clauses or general provisions that allow the business entity to make alterations. "Physicians need to be concerned about how quickly the contract can be changed," Mulgrew says. "Some have 30-day notice clauses, meaning their provisions can be altered in just 30 days." A physician's only recourse may be to drop out of the plan — "which could present a major problem if a substantial chunk of the physician's practice is tied up in the plan," Mulgrew says.

Many contracts are long and cumbersome, says Laura Allendorf of ASIM's Medical Advocacy Services, Inc. "But we're more concerned about the shorter ones. It's what's not said in the contract

that can create a lot of problems," she says.

For example, some contracts lack arbitration clauses which spell out how complaints or differences of opinion are to be handled should a physician have problems with the plan. Others are vague about quality assurance programs or conditions for termination. "These need to be sufficiently spelled out to the physician's benefit," says Allendorf.

Clousson also points to "loyalty clauses" which appear in some contracts and could compromise a physician's ability to deal honestly with his/her patients. In these clauses, "the physician agrees not to make any critical statements or adverse comments about the HMO," says Clousson. "This puts the physician in a terrible malpractice and ethical situation" should a problem arise and the physician wish to advise a patient contrary to what the HMO plan allows.

The issue of added professional liability involved in signing contracts is one of the major sections covered in the California Medical Association's recently revised *Physician's Contracting Handbook,* a 56-page booklet which addresses a number of concerns regarding contracts. Central to that issue is the so-called "hold harmless clause," which, in essence, places most if not all of the blame for any professional liability claims on the physician, leaving the business entity "held harmless."

"This is a major problem," says Laurel Rollins, program director of the American Medical Association's Department of Practice Management, which now sponsors an all-day seminar on alternative delivery systems and contracting. "A hold harmless clause leaves the physician completely open and liable for anything that might go wrong, while the HMO has none of the liability."

In 1985, the OSMA helped to eliminate the automatic inclusion of hold harmless clauses in contracts being distributed in Ohio by advising its members in the *OSMAgram* not to sign agreements with these clauses, says Mulgrew.

However, "the hold harmless issue has not gone away," Snelson observes. "It's still a major issue in contracting. Even if the sheer number of such clauses has decreased, the impact has not," she says.

Almost every contract, she and Mulgrew point out, in some way address the issue of indemnification. "There are other phrases or clauses that are equally bad (as hold harmless clauses)," Snelson says. "The bottom line is to make sure that your insurance company covers you if you join the plan."

The hold harmless issue is one of some 25 issues related to contracting that the OSMA Department of Legal Services has actively studied over the past three years. Others, says Mulgrew, revolve around treatment modalities and preadmission certification procedures. "Physicians need to look very seriously at utilization review," says Mulgrew, "and to determine if their practice patterns are





also critical, says Snelson, pointing out that many contracts being offered in California today include capitated payment systems. Here it is crucial that a financial advisor or accountant help evaluate the merits of the plan, she says. Factors to consider are the case mix of patients in the plan, the ages of those enrolled and the services that are covered by the capitation payment. It is also important to know what supplies or materials are to be taken out of the lump sum the physician is to be paid each month for treating patients.

The bottom line, says Snelson, is "Is the capitation amount per person, per month a good risk or a bad risk? How was this figure determined and how likely is it to meet your expenses, as well as to support your practice?"

Another important legal-medical area that should be addressed in every contract is "What happens if the HMO becomes insolvent?" says Rollins. "Termination of the plan may not end the patient-physician relationship," she points out. "The physician may end up having to treat the patients in the plan free of charge."

It is for all of these reasons that the OSMA's Department of Legal Services will be stepping up its efforts during 1987 to help physicians and their attorneys make wise decisions. Staff members will continue speaking to physician groups around the state on the many complexities of alternative delivery and financial systems — and all of the ramifications of contracting. By mid-year, says Mulgrew, an additional staff attorney will be assigned the task of reviewing contracts for physician members and helping them to understand all of their options.

Rollins agrees that physicians need to seek out professional, legal and financial help before putting their names on the bottom line of any contract. Yet, ultimately, the responsibility of living up to the provisions of the contract lies with the physician — so it is important that he or she completely understands the agreement. This is the chief reason the AMA developed and now offers its all-day seminar entitled "Alternative Delivery and Financing Systems: Your Options and How to Evaluate Them." The seminar was most recently offered in Cincinnati and will be held at other locations in the state in coming months, says Rollins.

"The workshop doesn't replace a full evaluation by a qualified attorney," says Rollins. "But neither does an evaluation replace the physician's understanding of the issues. Most contract evaluation services simply provide a detailed analysis of the contract. If the physician doesn't understand the issues involved, the analysis may not have much meaning."

What's more, "it's the physician's signature which ultimately goes on the contract," she adds. "He or she must decide whether or not it's a beneficial and workable one."

Susan Porter is the Associate Editor of the **Ohio State Medical Journal.**



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Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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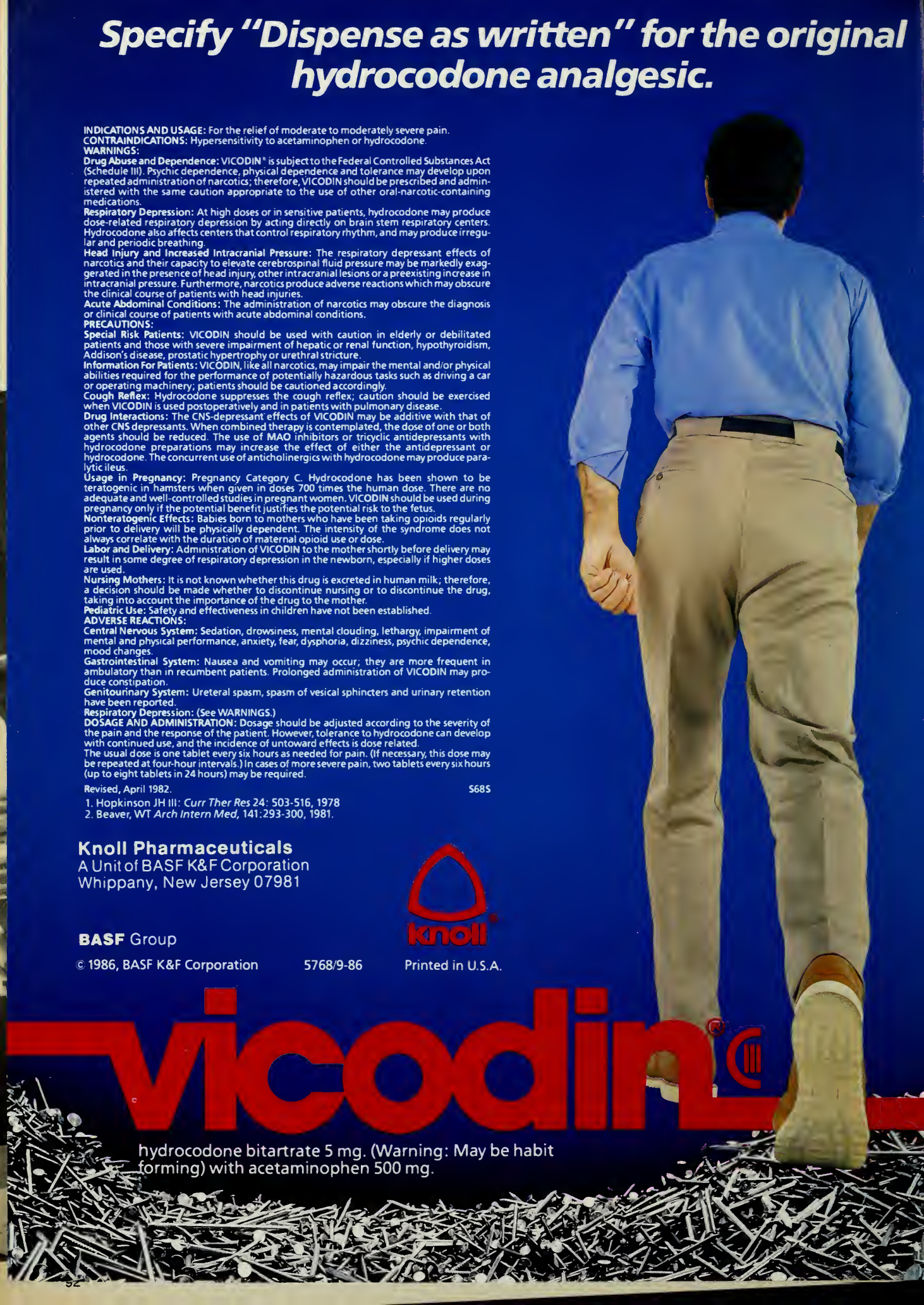
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What You Should Know Before You Sign

Remember, a contract, regardless of how informal or simple it may appear, is a legally binding agreement. Once you sign it, you have to live and work with it — no matter how absurd or impossible its provisions may turn out to be.

The following are some questions you may want to ask before you sign on the bottom line:

1. Exactly who is sponsoring the HMO, PPO or IPA you are considering joining? How well established is the sponsor in your area or community?
2. How financially sound is the sponsor? How long has the business entity existed and what is its track record in other areas or states?
3. How legally sound is the proposition being presented in the contract? Does this type of business conform to state and federal laws on how physicians may conduct business?
4. What are the antitrust implications of the arrangement you are about to make? Does the plan comply with both federal and state antitrust statutes and trade regulations?
5. How will involvement in the HMO, PPO or IPA affect your current practice? What potential does it hold for drawing new patients?
6. What other physicians and patients are participating in the plan? How are these physicians identified in the contract?
7. How many employer groups and other patients and patient groups are currently enrolled in the plan? How are patients in the plan identified?
8. What is the case mix of patients currently enrolled in the plan, including age, average number of claims and other demographics?
9. What specific services and supplies are covered for patients in the plan? What services are not covered and are these well specified to patients as well as to physicians?
10. Are services covered the same for all patients enrolled in the plan, or are different employee groups covered differently? If there are differences, how will you be informed of them?
11. What is the notice or lead time between any changes in "covered services" and your right to bill and be paid for services provided? Is there a time limit for the submission of claims?
12. What other specific cost-containment measures are included in the plan and how might these affect your ability to give quality care? Do you agree with these measures?
13. In what other ways does the plan restrict or control your ability to practice medicine? Does the contract limit the number of patients you may see each year?
14. Does the plan require that you be available on a 24-hour basis?
15. As a participating physician, how will your name be used in promotional materials, including listings, brochures and media advertising? What controls do you retain over the use of your name?
16. What prior authorization, utilization review and peer review guidelines and procedures are used in the program and who conducts them? Do these conform to your established standards of care? How might these hinder your ability to deliver quality care to your patients as you see fit?
17. How might involvement in utilization review and peer review activities affect your risk of professional liability? Does the organization provide coverage for those involved in these activities?
18. May you refer your patients to specialists and other physicians outside of the plan? If not, who will be responsible for medical services provided if you inadvertently refer a patient in the plan to a non-participating physician?
19. May you refer patients in the plan to hospitals, laboratories, x-ray facilities, etc. outside of the plan? If not, which hospitals and facilities are participating and are they convenient to your practice and your patients?
20. What procedures have been set for settling differences of opinion or disagreements which may arise from the contract relationship? What time-lines are given for settling these disputes? Will peers be involved in settling these

The OSMA Department of Legal Services helps physicians and their attorneys analyze contracts and answers their questions on the various components of contracting.

disputes? Does the arbitration clause preclude your ability to go to court if you so desire?

21. How much will you be reimbursed for patients in the plan? If you will be awarded on a fee-for-service basis, how does reimbursement compare with the fees you are currently receiving for treating patients?
22. If a capitation system is being used, how are reimbursement allotments arrived at? How much financial risk are you incurring by treating patients in the plan? Will capitation figures be enough to cover your expenses as well as to afford you some profit?
23. How frequently will you be paid for patients treated through the plan and what is the exact turn-around time on these claims? May you charge a penalty for those claims not paid within the designated time?
24. What type of billing procedures are to be used under the plan and how compatible are these with your current billing practices?
25. What additional overhead and office expenses might you incur by being involved in the program? How will these detract from revenues you will be receiving by being involved?
26. How does the contract address the issue of indemnity? How much liability are you assuming in the contract and how much are other parties assuming?
27. How does involvement in the program affect your professional liability? Does your current professional liability insurance cover your involvement in the program? Does the plan require that you increase the amount of your liability insurance in order to participate?
28. What provisions are provided for terminating the contract? What type of notice must you give if you decide to withdraw from the program? Does your involvement in the program automatically roll over should you not give notice?
29. What happens to patients under your care through the plan should you decide to terminate the contract? What happens to those patients should the plan fail or the plan decide to terminate its contract with you?
30. How may you inform your patients of your intent to leave the plan? May you advise patients to drop out of the plan as well?
31. Under what conditions may the business entity terminate its contract with you?
32. What power does the HMO, PPO, or IPA have to unilaterally change the contract? How much notice will you be given of any changes? Do you also have the right to make changes in the contract?
33. How complete is the contract? Are all documents referred to in the contract (fee schedules, utilization review procedures, etc.) attached? Are there any blank spaces in the contract?
34. Does signing the contract prohibit you from participating in other plans?
35. How are medical records to be handled under the plan? Do these procedures comply with state law and respect the confidential relationship you have with your patient?
36. What grievance procedures are used with the plan and how are members of grievance committees selected?

GROUP PRACTICE CONTRACTS

1. If you are being offered full-time employment with a group practice, how are you to be reimbursed? Will the method of reimbursement change after the first year? (Don't be misled by "first year guarantees" which may be inflated or contain added benefits simply to get you into the practice.) If so, what is the average salary you can expect to make after the first year?
2. What benefits are offered through the group and how do they figure into your total salary package? In some instances, benefits such as pension plans, health insurance and malpractice insurance may be offered, but deducted from your salary or the group's gross profits. Thus your take-home pay could be substantially lower than you anticipate.
3. How many hours a week will you be expected to work and how are those hours determined? Who is in charge

of scheduling and how frequently will you be expected to work evening and weekend hours?

4. What provisions are available for buying into the partnership and how much will it cost you? Are special financial arrangements available for buy-ins, such as low-interest loans provided by the practice or salary deductions — or will you be expected to come up with the total figure? What buy-out arrangements are available should you decide to leave the practice?
5. How much does the group average in annual billings and what percentage of these and/or your own billings will you retain? Remember, a smaller percentage of a large total may reap you a higher income than a high percentage of smaller billings.
6. What are the group's financial obligations and how will its long-term and short-term debts affect your income? What additional financial liabilities might you incur by becoming a member of the group?
7. Do you agree with the group's policies and procedures — both operational and clinical? How much freedom and flexibility will you be given to practice medicine as you see fit?
8. How qualified and effective are the office manager and other non-physician staff members working for the group? What are the group's policies regarding the hiring and firing of these personnel and how much input are physicians given in these matters?
9. Do physicians have adequate voice in the financial planning and other business decision-making processes of the practice? Who determines when and how major pieces of equipment will be purchased that could affect your practice — as well as your income.
10. What is the group's total share of the patient market in your specialty and how has this changed over the past several years? Has the group adopted and implemented a well-planned marketing strategy to retain and attract patients?

CONTRACTS WITH HOSPITALS

1. What types of services are you expected to provide to the hospital and its patients? How much time are you expected to spend rendering these services?
2. How are you to be reimbursed for each of the various services you may provide (e.g., patient care, teaching activities, administrative work, etc.)? How do current government regulations affect the amount of reimbursement you will receive?
3. Does the hospital provide free billing and collection services for physicians, or are physicians required to handle their own billings?
4. Does the hospital require that



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JOINT VENTURE CONTRACTS

1. What is the scope of activity or services the joint venture will encompass? How economically sound is the concept from a business standpoint?
2. Exactly who are the other parties involved in the joint venture (hospitals, physicians, other investors, etc.)?
3. Under what form or business entity (partnership, corporation, etc.) will the joint venture operate?
4. How will involvement in the joint venture benefit your practice and your patients?
5. What type of financial contribution or investment must you make? How does this compare with what other participants are contributing to the joint venture?
6. How will the joint venture be managed? What input will you have into the management and decision making processes?
7. What is the financial gain you can expect to make from the venture and how long will it take you to recoup your investment?
8. Are there tax advantages involved in participating in the venture? How have the new tax laws changed those advantages?
9. What are your financial risks, should the venture fail? Is your personal property at risk along with your capital investment?
10. What other liabilities might you be incurring as a participant in the joint venture and how do these compare to the risks being taken by other partners? Will these liabilities be covered by your current malpractice insurance?
11. Should you decide it is no longer to your advantage to participate in the joint venture, can you sell your share? If so, how will you be reimbursed for your investment?

It is the question of the eighties. Exactly where should the line be drawn between the public's right to be protected from those impaired by drugs and its right to protect itself from unwarranted invasions of privacy.

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Registration Fee: $75.00
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Call the OSMA Department of Health Education for more information at 614/228-6971 or see the February issue of the OSMAgram for registration form.



Reliable Deterrent or Threat to Privacy?

A Public Forum on the Issue of Drug Testing Sponsored by the Ohio State Medical Association

What Now After Tax Reform?

By John E. Sestina

SMB Financial Planning Inc.

By now most physicians have figured out they will not pay less taxes as a result of tax reform. Articles proliferate with explanations of lower tax brackets and how "loopholes" have been eliminated. Advisors are scurrying with attempts to help the physician understand how bad things will be. Few articles point out what is still possible as a positive.

The major danger facing the physician is a reflex action to tax reform which assumes some of the tools and planning that were able to be utilized in the past are no longer effective. Already, general advice which may not be applicable to the individual is predominating all of the periodicals. This article will attempt to show you there *is* life after tax reform.

The best thing resulting from tax reform is the elimination of tax shelters as we knew them. The professional, non-sales oriented advisor had a tremendous task in trying to talk the physician out of throwing money away into tax shelter deals that made no economic sense. Rather than a systematic program for improving his or her economic position, the physician would react at the end of the year to an anticipated tax bill, or a convincing salesman. Fortunately, now, this should no longer be the case.

The physician should be looking for ways to reduce the tax bill with those available tools which will serve both short-term and long-term. Remember, the financial game you are playing is not who is paying the least taxes, but who ends up with the most money. The way to accumulate the most money is to understand how much you really need to meet your short-term and long-term objectives. Without knowing what is "enough" the physician will always be working from the position of "more." When you work from that position, then you continue to be a target for reactionary decisions. After you have determined these objectives and know how much is "enough," you will then be able to select the appropriate tools to help you accomplish those objectives. Those tools should enable you to *deduct, defer, split* and *convert* income to reduce your taxes.

Deduct

If you know how much you need to be investing to get where you want to go, and determine a method to invest on a tax deductible basis, one of two advantages occur. Either you can meet your goal earlier or you can reduce the amount of investing you now have to do. If you reduce the amount of investing you do currently, you can then use those funds to improve your lifestyle now — not 20 years from now. As an example, assume you determine you need to invest $25,000 per year. In the normal course of events you would have to earn a pretax income of approximately $36,000, pay $11,000 in taxes (30%) and only be able to invest $25,000 per year. In the old days, the physician would pull out this $36,000 as salary and look for a way to buy a tax shelter which might recover some of the taxes. On the other hand, if the physician can cause the savings to be deductible, the $11,000 tax is



eliminated. Therefore, making the annual investment deductible can improve the physician's lifestyle immediately, in this case to the tune of $11,000 before tax.

Defer

Should the physician, in addition, be able to defer the taxes on his investment earnings, he will also accumulate the necessary total funds sooner. If the physician invests $25,000 per year and it earns 8% per year, he will only have an after-tax return of approximately 5.6% (the other 2.4% went to pay taxes on the earnings). At the end of 20 years an investment earning 5.6% will accumulate to $881,000. The same $25,000 deferring the income taxes will be worth $1,144,000 at the end of the same period. If the goal was to have accumulated only the $881,000, the physician could reduce his savings to $19,250 per year for 20 years or he could accomplish his goal in approximately 17 years.

Split

If a physician has a taxable income of $100,000, his taxes will be approximately $30,000. If, on the other hand, he has an opportunity to split that income into two parts he can save taxes. Assume he splits it into $40,000 and $60,000. The taxes would be $6,000 and $18,000 for a total of only $24,000 with the right tool. The more the physician can split his income the less taxes he will pay. Assume the physician can further split the $40,000 into $15,000 and $25,000. His taxes are now reduced to $18,000 on the $60,000, $3,750 on the $25,000, and zero on the $15,000 for a total of $20,750—again, assuming the doctor uses the right tools. An important point is that you can only determine how to split your income when you know what is "enough." Enough to live on now. Enough to save for the future.

Convert

Some expenses the physician now pays are not deductible. By the proper use of tools, those non-deductible expenses can become deductible.

What are the Tools?

If you have not figured it out yet, the tools are those good old staples: IRA, corporation, pension and profit sharing plans.

It is true all of these tools bring with them some additional cost. Perhaps the cost is additional legal or accounting fees as well as employee costs. Nonetheless, their value generally outweighs those

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Next month in:

OHIO Medicine
JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION
VOL. 83, NO. 3 MARCH, 1987



Is there a place for the adolescent patient?

An in-depth look at one of medicine's newest specialties — adolescent medicine — celebrating its tenth anniversary this year.

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Even though some of the changes may seem dramatic to you, recognize you must play this hand with the cards dealt.

costs.

It is also true that some of the advantages of these tools have been lessened by tax reform, but not to the extent that you should abandon them. The IRA, for example, still makes sense even though you may not be able to deduct the contribution. The reason it does is because of the continued ability to defer the taxes on the accumulation. As illustrated above, deferral helps you achieve your goal sooner or better.

The corporation still permits you to accumulate money and invest it within the corporation on a more favorable tax basis than you probably can do outside of the corporation. An example of this is the continued availability to have dividends earned by a corporation excluded to the tune of 80% of that dividend.

Many argue you must pay the piper eventually. For the most part, they are right. However, this argument is shortsighted or a reflection of a lack of understanding of compound interest. If you assume that at the accomplishment of your goal you will irresponsibly withdraw your funds from these tools, they may be right. However, just as there is the opportunity to use these tools while you are accumulating funds, there is a priority of withdrawal. The longer you defer the taxes at that time the more advantageous the deferral becomes.

Most importantly, the physician should recognize that tax reform has not changed the fundamental need for an organized approach toward the accomplishment of his goals. Further, he should know that with these tools he can probably make his goals while at the same time improve his lifestyle each year. The journey begins by deciding what it is that you want. Then, only use as many of the tools as necessary to accomplish your goals. After you fund your goals and find there is more, you should spend it now. Ultimately, these tools result in you taking less risk with fewer headaches, and you end up with the best result of all: peace of mind.

Even though some of the changes may seem dramatic to you, recognize you must play this hand with the cards dealt. Also, take advantage of what you have now. Consider how much better off your peers are who have acted with what was available while it was available.

John E. Sestina is a vice president with SMB FINANCIAL PLANNING, INC., a member of the PICO Financial Services Group which provides specialized financial planning services to physicians and other professional individuals and corporations on a fee only basis.

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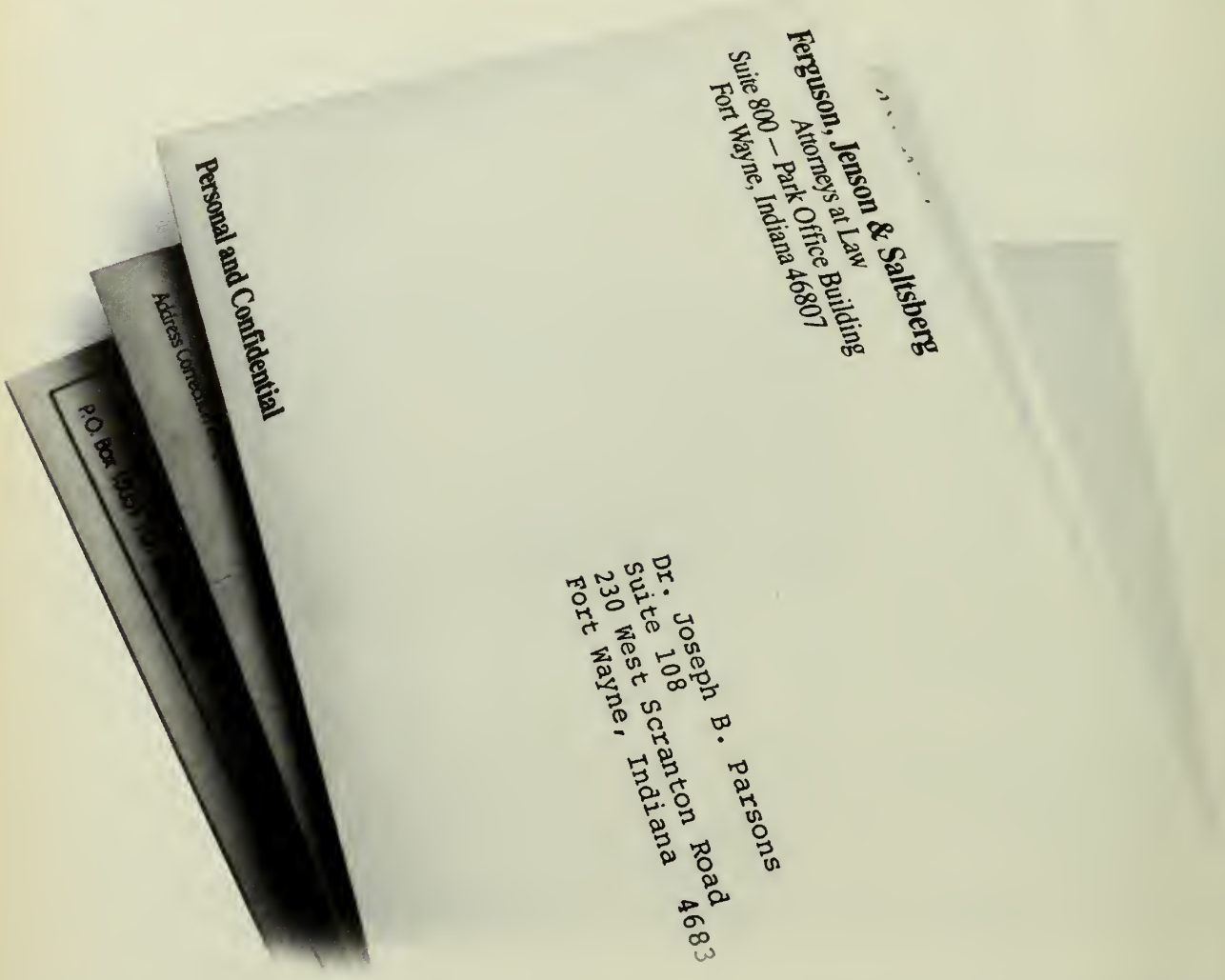
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OSMA AUXILIARY
1987 Day at the Legislature

Wednesday, March 11, 1987
Hyatt on Capitol Square
75 East State Street
Columbus, Ohio

You are cordially invited to meet the 117th General Assembly, who will be our guests for luncheon at the 1987 "Day at the Legislature." Greet old friends from this august body and meet the newly elected legislators!

The day will begin with briefings on current state and federal legislative issues of interest to the health care profession and a preview of trends and actions that might be expected in the new Legislature and Congress.

State Representative Jo Ann Davidson, who is representing the 34th House District in her 4th term, will share her experiences as a woman in public office and discuss the importance of participation. Representative Davidson serves as the Assistant Minority Whip of the Ohio House Republicans and is employed by the Ohio Chamber of Commerce as First Vice President of Special Programs.

Following luncheon with your legislator, you may choose to attend the Session and pertinent committee hearings with members of the OSMA legislative staff or participate in a workshop led by OSMA Auxilians and others who were actively involved in various aspects of political campaigns in 1986. The theme of last year's "Day" was grassroots participation. Hear from some who "took the plunge" and had a grand and stimulating time doing it!

— *PROGRAM* —

8:30 A.M.	Registration & Continental Breakfast
9:30 A.M.	Briefing on Current Federal Legislative Issues — AMA Department of Legislation
10:15 A.M.	Briefing on Current State Legislative Issues — OSMA Department of Legislation
11:00 A.M.	WOMEN IN POLITICS — THE IMPORTANCE OF PARTICIPATION Representative Jo Ann Davidson, (R-Reynoldsburg) 34th House District
NOON	Luncheon with Legislators
1:30 P.M.	Attend Session/Committee Hearings
	Workshop — "Political Barnstorming — Don't Be Afraid!" Panel of OSMA Auxilians who participated actively in 1986 political campaigns

Registration Fee: $25 per person, includes continental breakfast, luncheon, workshop, materials

Menu:

Continental Breakfast
Fresh Fruit or Juice
Assorted Bakery Breakfast Breads
Butter and Preserves
Beverage

Luncheon
Oriental Beef Stir Fry with
vegetables on bed of rice
Salad
Dessert
Beverage

Committee: Barbara Marshall, Montgomery County, Chairman; Marcia Barkey, Hancock County; Sally Gates, Hamilton County; Joan Swedlund, Huron County; Pat Vanetta, Trumbull County.

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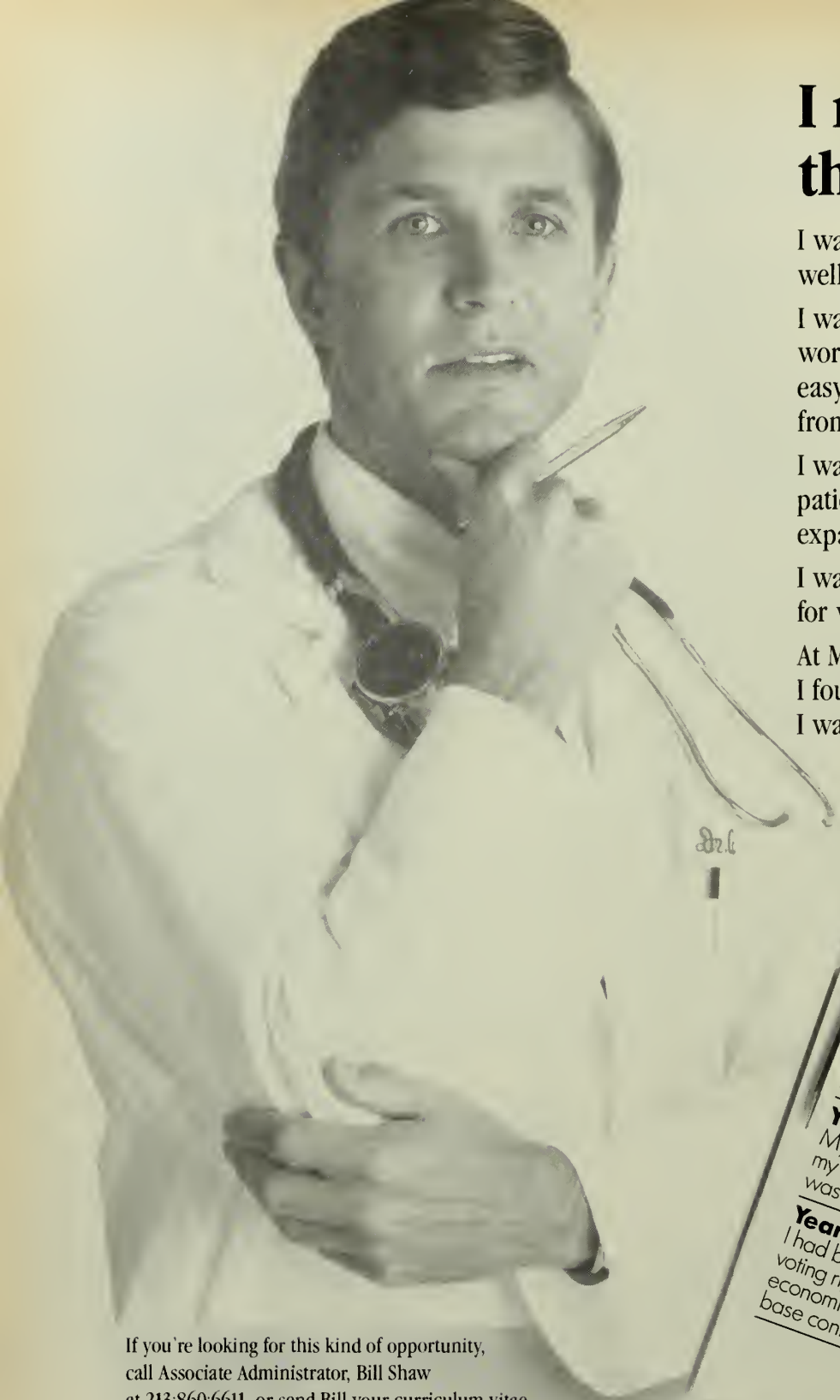
_____ Will attend Session and Committee Hearings

_____ Will attend workshop

Make checks payable to: OSMA Auxiliary Total Enclosed $_____

Reservation deadline Feb. 18, 1987 to: Barbara Marshall, 3151 Sunnycrest Lane, Dayton 45419

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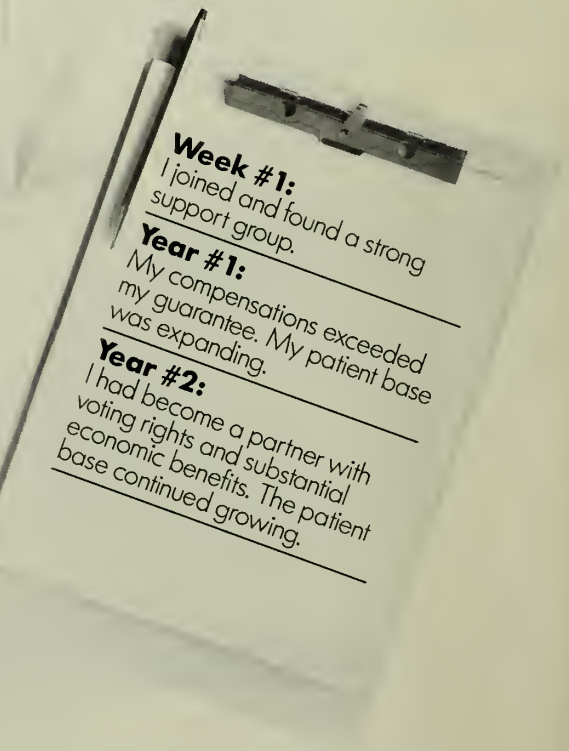
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A Man of Letters

"There is no doubt that men also express their character through their handwriting." — Sigmund Freud

By Deborah Athy

Hurriedly written grocery lists, frenzied class notes, scribbled phone messages, and even doodles: There's more there than meets the eye, according to a Ravenna physician who, since 1981, has been studiously reading between the lines. Instead of the traditional and obvious assimilation of words in order to derive meaning, Rogelio Marcial, MD employs a reading-style extraordinaire, a.k.a. graphoanalysis, in which he deciphers the curves, spaces, swells, slant, curlicues, dots, sweep and shape of the letters themselves to unravel the story behind the story.

"Graphoanalysis is a specific system of delineating personality traits through the study and evaluation of strokes and stroke formation in handwriting," according to a brochure from the International Analysis Society.

Italian physician Camillo Baldi wrote the first treatise on handwriting analysis in 1622, but it wasn't until the 20th century that the link between *personality* and penmanship was fashioned. In 1915, Milton Newman Bunker, a teacher of shorthand, noticed the variance of styles in his students' shorthand strokes and, with help from other scholars of letters, devised the system of graphoanalysis.

Dr. Marcial happened upon the study of handwriting by a stroke of luck; he received a flyer in the mail which offered a correspondence course in graphoanalysis. Some 18 months of lessons, letters, studies and exams later, he received certification as a graphoanalyst.

It is no wonder, then, that Dr. Marcial regards the old pen-and-paper routine as much more than just a mechanical process or a learned skill. It is not *your hand* that is scribbling away, he says — it is *your brain.*

"What the brain conceives is transferred to your hands," he explains. Writing, or "brain writing" as he calls it, is like "putting on paper a picture of the way you think."

Dr. Marcial refers to individuals who, after losing their hands or fingers in an accident, continue to exhibit the same writing traits even when the pen is held between the teeth, toes, or in the crook of the elbow.

Many people are taught to write cursive script in a similar fashion; one of the more traditional writing guides — in addition to one's parents, siblings and the second-grade teacher with a handful of chalk — is the rendition of the alphabet often featured above the chalkboard in elementary school classrooms: crisp, perfectly crafted letters on a bright green background.

But a person's handwriting is akin to the proverbial fingerprint phenomenon: no two are alike; no two signatures, dear John letters or phone book doodles. The



particularity of technique in a person's John Hancock is the very source which reveals aspects of a person's personality.

Emotions, fears, will power, determination, social integrity, defenses, aptitude, goals — all of these elements can be deciphered by a skilled handwriting analyst, says Dr. Marcial. In fact, handwriting traits which characterize violence can also be recognized; that is, one may be able to pinpoint a potential murderer by perusing his or her handwriting.

But a single stroke or trait does not tell the whole story, he emphasizes. A handwriting analyst first identifies particular strokes, relates these strokes to specific personality traits, and then evaluates the relative strength of the interrelating traits, he explains. An analyst doesn't conclude that someone is vicious or benevolent just because of one stroke trait. One trait may diminish or offset a negative trait or, then again, it may aggravate and intensify it.

In any case, in order to draw "the whole composite personality of an individual," Dr. Marcial prefers to work with at least 100 letters; anything else is really a superficial analysis, he explains.

A family practitioner for 25 years, Dr. Marcial includes psychotherapy, hypnosis and acupuncture in his repertoire of medical services. Graphoanalysis is a plus, he says, and can be used to supplement dream analysis. When a patient writes about the details of a dream, Dr. Marcial not only analyzes the details, but also examines the handwriting for hidden meanings, escape valves, stress, repression, etc.

"Most psychiatrists do believe there is a correlation between the constitutional, mental and emotional character of an individual and the way he forms his strokes in handwriting," he points out.

Dr. Marcial admits that he has found himself espying the penmanship of other doctors, family members, etc. "I have found myself looking at the strokes — not even reading what the writing consists of . . ."

For example, sometimes on rounds he will notice a new physician's handwriting and will almost automatically formulate a hypothesis about that person's personality; Dr. Marcial says he's batting about 90% accuracy in pinpointing the nature of new physicians.

Which leads to an interesting subject . . . the fact that physicians, in general, have an incredibly notorious reputation for their handwriting. They are almost universally harangued for being scribblers; many people believe that doctors may as well write in Latin all the time since their writing is unreadable anyway.

But Dr. Marcial does his fellow physicians a kind service by explaining that the sometimes-undecipherable scrawl on prescription pads, examination forms, etc. is due to the simple fact that doctors are almost always in a rush. And, in addition, scribbling one's name as opposed to carefully penning it makes no difference in as far as personality analysis is concerned, because the same traits show up, he says.

Graphoanalysis is put together in a highly standardized scientific method, and like any other scientific tool or measuring device, it is susceptible to failure. Reliability and accuracy "depend on the skill of the analyst," he explains.

And while handwriting analysis is not something one can decipher the future with, there has been

some conjecture about the relationship of handwriting to medical diagnosis; that is, can a person's handwriting show whether he or she will develop some type of illness? Dr. Marcial emphasizes that this kind of thought is still in its infancy.

For the time being, handwriting analysis is used in more practical ways, such as in personnel selection, identifying credit risks, social work, teaching, as well as in newsworthy applications, such as verifying the authenticity of Hitler's diaries and Howard Hughes' wills.

And what about Dr. Marcial himself . . . how does his handwriting stack up? At first, he admits he was a little skeptical about what his handwriting indicated about his personality. "I would think 'I'm not like that,' about things that were really true," he remembers. But by and by, he says, "I have learned more about myself and have gained more insight" into who I really am.

Deborah Athy is Assistant Editor of the **Ohio State Medical Journal.**

The Write Stuff

Do people ever comment about your writing? It's too small, messy, flowery, flamboyant or unreadable. Or better yet, it's unique, artistic, traditional.

The following questions and descriptions may unearth *a little* about the real you that your handwriting reflects.

Rogelio Marcial, MD, a family practitioner from Ravenna and a certified graphoanalyst, emphasizes that these are *general* traits and, taken separately, cannot accurately pinpoint your personality.

But just for fun, grab a scrap of your handwriting — things-to-do list, medical notes, an old letter — and compare.

• Do you loop your letters (l, t, h)? Looping the stems of letters often denotes sensitivity; the bigger the loop, the more sensitive the individual.

• Do you completely close the letters "o" and "a"? If you leave these vowels slightly ajar, you're the communicative, outgoing sort. If you don't, you may tend to be more introspective.

• How do you cross your "t's"? A very highly crossed "t" indicates self-confidence and ambition. A lower crossed "t" might indicate low self-esteem. If the cross stroke misses the "t" entirely, you may nurture unrealistic goals.

• How far do you bring down your strokes on letters such as "y," "g" and "f" (below the line, for example)? If you tend to extend your strokes down below the line, you may be a very determined individual.

• Are there a lot of breaks between your letters in a word, instead of writing in one continuous stroke? If so, you may have a touch of intuition.

• How do you dot your "i's"? A nice, round dot above the "i" indicates loyalty and attention to detail. An off-centered slash may denote sarcasm or temper.

• Do you retrace your letters when writing — "n" or "t," for example? This could be an indication of repression.

• How wide are your circles in the letters "e" and "a"? Wide, round circles indicate open-mindedness and vice versa.

• Do you press down heavily on the page with your pen or pencil, or do you write lightly, simply gliding across the paper? If you press down very hard — leaving indentations on the page underneath — you may find it very hard to let go of bad incidents in the past. On the other hand, if your writing is light and soft, you may find it easier to forget the bad and get on with the present.

• Are the letters "n," "m" and "r" rounded or pointed? Rounded letters mean you tend to accumulate the facts first and then make a decision. Pointed letters show an analytical side . . . you absorb things right away and decide.

• Does your writing slant to the left, right, or is it straight up and down? A strong slant to the right may denote emotional responsiveness; to the left, a tendency toward being introverted or maybe even withdrawn; up and down, well-poised on the surface, but keeps emotions inside.

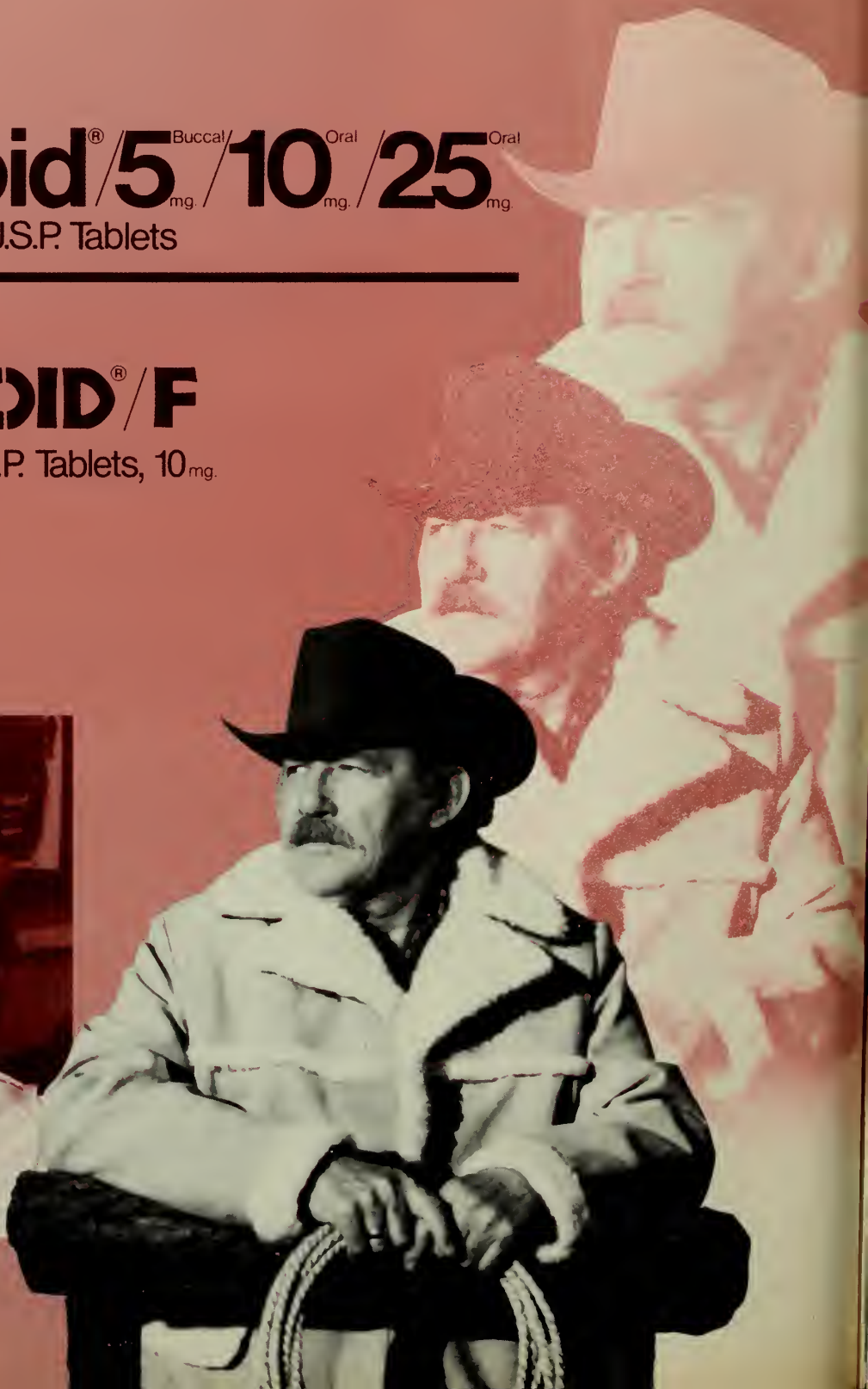
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Cathy Costello joined the OSMA legislative staff as Assistant Director in 1981, after completing studies at the Ohio State University College of Law and serving as an intern at the OSMA while in school. In 1982-84, she served as Associate Staff Counsel of the OSMA, and in 1984 was named Director of State Legislation. In her current position of Staff Counsel and Director of the Health Law, she supervises a variety of OSMA legal efforts.

Doug Graff joined the OSMA Department of Legal Services as Assistant Staff Counsel in 1985, after graduation from the Ohio State University College of Law. He previously served on the staff of a Presidential and Congressional advisory body on compensatory education and as a research assistant at the Ohio State University College of Medicine, Department of Physiology. He worked for the firm of Cloppert, Portman, Sauter and Latanick in 1984-1985. Doug has a B.A. in Political Science, Economics and Speech and a Masters in Public Administration.

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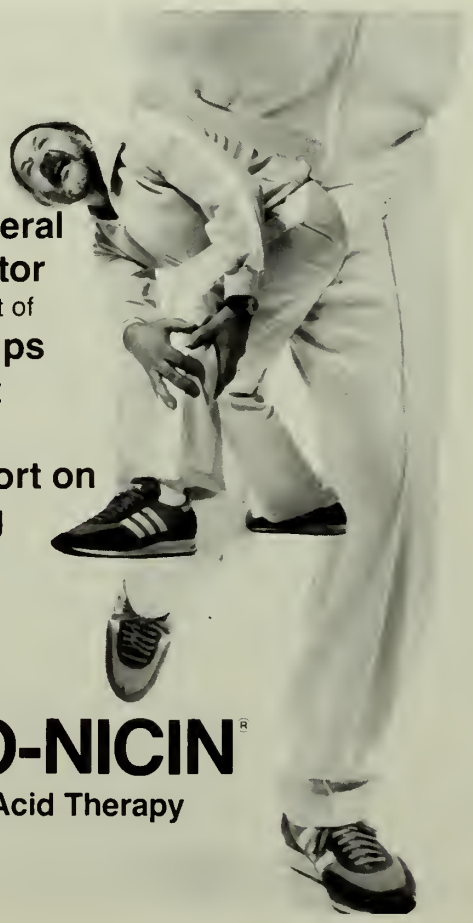
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EXPENSE

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TOBACCO'S RADIATION: ITS SOURCES AND POTENTIAL HAZARDS

Syed M. Rahman, MD
Craig P. Albert, MD
Balbir S. Reehal, PhD

Cigarette smoke contains trace amounts of Alpha-particle emitting radioactive elements of polonium-210 and lead-210. Data have been reported indicating that an increased amount of this radiation is found in lungs of smokers. This radiation must have contributary effects either additive or synergistic in the initiation of bronchogenic cancer in cigarette smokers.

While the vast majority of the population has a partial awareness of the dangers from chemicals in tobacco and in cigarette smoke, most physicians remain ignorant to tobacco's radiation hazards. Even though research in this area began over 20 years ago, distribution of this information has spread very slowly to the medical community. There were greater than 50 million cigarette smokers in America in 1977, each with an average consumption of over 11,000 cigarettes per year; the number of smokers has grown considerably in the past decade. It is important to alert physicians and other primary caretakers to the radioactivity contained in cigarette smoke. The following discussion reviews some of the pertinent studies over the past three decades.

The radioactive isotopes found in tobacco are carbon-14, lead-210 (Pb-210), polonium-210 (Po-210), thorium-228, 230, 232, radium-226, 228, plutonium-239, 240 and potassium-40.[1] Pb-210 and Po-210 are of most interest to us for their role as possible carcinogens and also for their volatile nature at temperatures found in burning cigarettes (600-800°C). As a smoker lights up, these isotopes can be easily liberated into the cigarette smoke. In fact, mainstream smoke (smoke drawn through the cigarette) contains about 30-50% of the total Po-210 concentration in the cigarette.[2] This concentration appears to be significant, especially when considering that Po-210 is responsible for greater than 99% of the alpha radiation activity in cigarette smoke condensate, despite the presence of radium and thorium.[1] Reducing the amount of Po-210 in smoke by use of filters is open to debate. Bretthauer et al found that up to 90% of the Po-210 can be extracted by filters.[2] Whereas Radford et al detected no significant difference in Po-210 concentration in smoke between filtered and non-filtered brands of cigarettes.[3]

Radiation from these sources is of particulate type (i.e. alpha particle emission) having shallow tissue penetration, but a high LET.* Both Pb-210 and Po-210 are daughter isotopes of radium

Syed M. Rahman, MD, Director of Radiation Oncology Service; Craig P. Albert, MD, Special Trainee; and Balbir S. Reehal, PhD, Chief Physicist, Department of Radiation Oncology, all of the Grant Medical Center in Columbus.

**LET (linear energy transfer) is the transfer of energy per unit length of the radiation path. Low LET (X, β, γ-rays) has the capacity to penetrate deep into tissues with only sparse tissue damaging interactions. High LET (characteristic of alpha particles) radiation has only superficial penetration powers, but is capable of producing greater biological damage over a smaller depth.*

with Po-210 being the final radioactive link in this chain of decaying elements. Po-210 and Pb-210 are in equilibrium with each other having a half-life of 138 days and 21 years, respectively. Actually, Po-210 is the alpha particle emitter (high LET) and Pb-210 gives off beta particle radiation (low LET).[4] However, because of their equilibrium, Po-210 and its high LET radiation can be present for periods much longer than would be predicted from its half-life alone.[5]

Several units are used for the measurement and dose specification of ionizing radiation. A RAD, or Radiation Absorbed Dose (quantitative term), is a unit of absorbed dose which is equal to 100 ergs of radiation energy absorbed by one gram of tissue. Since particulate radiation produces more biological damage than X-rays for the same absorbed dose, another unit called REM, or Radiation Equivalent Man (qualitative term), is used which is the amount of radiation that produces the same biological damage as one RAD of X-rays. One RAD of alpha particles produces as much damage as 10-20 RADs of X-rays and, therefore, is comparable to 10-20 REMs. Skin dose from a single chest X-ray is equivalent to only 0.03 REMs.[6]

The origins of the radioactive materials in tobacco can be explained in a few different ways. Tso et al believed that the primary mode of contamination is through soil fertilizers and their uptake by root systems.[7] There are radioactive elements in certain common phosphate fertilizers that are abundant with radium-226, Pb-210 and Po-210.[5] Around the same time, Francis et al wrote that the radioactive isotopes were deposited into soils by atmospheric radiation via rainfall and then taken up by the root system.[8] In 1974, Martell began studying trichomes (microscopic glandular hair) on tobacco leaf surfaces. He reasoned that the trichomes, acting as effective air filters, collect and trap radioactive aitkens (microscopic air particles concentrated with Po-210 and Pb-210) from the atmosphere. His results showed that thousands of these aitkens can accumulate on a single sticky trichome throughout a plant's life.[9] Harley et al compared various species of tobacco plants evaluating their ability to collect atmospheric Po-210. They found a significant difference in the trapping capacity related to the species' leaf characteristics. Species with numerous trichomes had over twice the amount of Po-210 of that deposited on species sparse with trichomes.[10] Although this discrepancy in radioactive particle concentration between tobacco plant species cannot be solely attributed to leaves' glandular hair, the variance uncovered in this study is supportive of Martell's theory.

Preliminary studies by Little et al (1965) and by Radford et al (1964) have shown that for chronic smokers (1½-2 packs per day for 25 years), the total radiation dose to lung tissue will approach 20 RADS.[3,5,11] Since we are dealing with high LET alpha radiation as opposed to low LET X-ray radiation, a relative biological effectiveness factor of 10 to 20 should be employed. Thus these lungs could be exposed to as much as 200 to 400 REMs of radiation over a 25-year period.[3,5,9,11] During this same period of time, only a 5 REM exposure dose would be expected from "background" radiation.*[3] Assuming these dosage estimates to be correct, chronic smokers could be said to receive approximately 8 to 16 REMs per year or the equivalent of about 267-534 chest X-rays per year.

More recent studies by Parfenov (1974) and Cohen et al (1979) determined the Po-210 concentrations in whole lung to be only 2.6 times greater in smokers than in non-smokers.[13] This concentration disparity is not as considerable as the earlier estimates. One possible explanation for earlier overestimations is due to the fact that even non-smokers have trace amounts of Po-210 previously unrecognized in the lungs. These small pulmonary concentrations occur mainly from inhaled and ingested Pb-210 which becomes deposited in skeletal bone via the circulatory system.[14] Bone thus acts as an internal reservoir for lead's decay by-product, Po-210, which can migrate to lung tissue. Nonetheless, in 1980 Cohen et al used a new technique (nuclear track-etch film) to measure ultra low alpha radioactivity in basal cells of human bronchial epithelium.[15] The study employed only seven subjects (three smokers — one of whom was only 23 years old; three ex-smokers; and one non-smoker) and revealed low mean alpha doses to the bronchial basal cells. However, an area 2mm by 6mm was detected in one smoker to contain exceptionally elevated activity which could produce an annual dose equivalent of 1 RAD (10 to 20 REMs) per year. The dose from this "hot spot" is of a greater magnitude than predicted by the earlier studies of Radford and Little.

This information must be tempered by other factors which confound the accuracy of these dosage estimates. It has been shown that the first response by bronchi to cigarette smoke and its carcinogens is a hyperplasia of the basal cell layer (from a 1-2 cell layer thickness to > 3).[16] This occurs prior to any precancerous changes. As these cell layers proliferate and thicken, the radiation must penetrate through increased tissue depth. Thus, the amount of radiation striking the basal cell layer is decreased. This becomes especially important with alpha radiation; even though it is potentially more damaging than X or gamma rays, its penetration power is weaker.[17]

On the other hand, a more significant effect concerns the ciliostatic action of cigarette smoke. It has been demonstrated by Falk et al that cigarette smoke slows the rate of mucous flow and interferes with cilial functioning.[18] With chronic smokers, Po-210 and Pb-210's clearance by the lung would be diminished. Subsequently, the lung tissue exposure time to radioactive particles would be increased. Thus, the lungs of chronic smokers having poor cilial and particle clearance abilities will be more vulnerable to the higher radiation doses.

Another important consideration related to the lung's clearance abilities is the distribution of radiation within the lung itself. Little et al showed that the lung parenchyma contained a relatively small concentration of Po-210 when compared to the bronchial epithelium. This is probably a reflection of particle clearance. Furthermore, he documented that within the bronchial epithelium, the Po-210 concentrations were about five times greater in the segmental bifurcations (upper and lower lobes). This suggests that a precipitating effect occurs at these bifurcations, creating "hot spots" of insoluble radioactive particle.[5,13] This finding would correlate well with the "hot spot" Cohen et al discovered in their one smoker. Martell has investigated radiation doses of "hot spots," too. He recently found that smokers of one pack per day can be exposed from 61 to 143 RADS during the same time period. He concluded that most smokers dying of lung cancer absorb a dose from 80 to 100 RADs.[4]

Radiation and Cancer

There is much evidence supporting the carcinogenic action of radiation. Results with laboratory animals have confirmed Po-210's tumorigenic capabilities. Yuile et al proved this action with Po-210 inhalation in rat lungs.[19] Kennedy et al using Syrian Golden hamsters and intratracheal instillations of Po-210 illustrated a dose-response relationship with bronchoadenocarcinoma.[20] A synergistic action between Po-210 and benzo(a) pyrene — a carcinogenic tobacco smoke constitutent — was revealed in their concurrent administration.[21] Little et al (1978) demonstrated that long-term exposure to low dose radiation from Po-210 was more effective than intermittent short-term moderate doses in producing pulmonary tumors in Syrian hamsters.[22] Caution must be exercised when extrapolating these animal studies to the human population, especially considering that

"Background" radiation is the radiation individuals absorb from common natural sources (terrestrial, cosmic and internal) through the course of daily living.[12] The "background" radiation exposure dose has been estimated to be between 0.08-0.20 REMs per year.[3]

most animal lung cancers are bronchoalveolar instead of bronchogenic (the common variant in humans). Nevertheless, these studies clearly show that carcinogenic activity of radioactive elements, more specifically Po-210, is demonstrable on live animal tissue and that uniform low dose radiation is sufficient to induce tumor formation.

In humans, certain tissues have been shown to be very sensitive to radiation. The most susceptible of tissues are: the female breast, the female thyroid gland, leukemoid tissue (especially myeloid) and the lung (more specifically the bronchi).[6,23] The statistics on location and frequency of lung cancer correlate well with alpha radiation "hot spots." Auerbach et al identified that bronchi epithelial changes — hypertrophy, cilia loss and the presence of atypical cells — in smokers' lungs occurred with a higher frequency at the bifurcations.[24] As early as 1955, Ermala et al uncovered a striking relationship between the clinical incidence of lung cancer and localized tobacco deposits.[25] Specifically, a high correlation, between the areas of reported cancer incidence and the percentage of total particle deposition within the five lobar bronchi, was unveiled by Schlesinger et al.[26] In fact, 90-95% of the cases of lung tumors are bronchogenic cancers;[4] and 90% of these are found in smokers.[27] In addition, they most frequently arise in the proximal bronchial tree, the area corresponding to the highest radiation concentrations.

Uranium miners have become an excellent human population for evaluating the effect of radiation on lung tissue. This group is occupationally exposed to alpha radiation from short-lived radon daughters in the atmosphere of mines. J.W. Gofman, in his book "Radiation and Human Health," discussed a study of Saccomanno (1978) who reviewed 280 Colorado miners who died from lung cancer. Smokers working in a non-uranium mine contracted fatal lung cancer 21 times more frequently than their non-smoking co-workers. Miners who both smoked and had labored in uranium mines died 56 times more often than did non-smokers in non-uranium mines.[27] This clearly suggests a synergy between cigarettes and alpha particle radiation. Along the same lines of investigations, Brandon et al established a strong correlation between lung cancer in uranium miners and the prevalence of aberrations in lymphocytic chromosomes.[28] He, thus, developed a cytogenic test employing cultured peripheral blood lymphocytes. This implies that high risk individuals — those exposed to prolonged levels of radiation — may someday be accurately examined for their chances of developing cancer.

The rate of contracting lung cancer has, in the past 30 years, been growing in an exponential fashion. This rate increase is equally applicable to both male and female populations. Currently, lung cancer is responsible for 25-30% of all cancer-related deaths. In fact, it has been estimated that over one million Americans will succumb to lung cancer in the 1980s.[29]

Conclusion

This article has tried to review the current literature on cigarette smoke and radiation-induced cancer. It has been clearly established that tobacco and cigarette smoke contain radioactive elements, more specifically Po-210. Furthermore, Po-210 has been demonstrated to possess carcinogenic properties in experimental conditions with laboratory animals.

An underlying question which needs to be addressed is, "What is the exact nature of the relationship between these radioactive deposits and the genesis of smoking-related lung cancer?" Unfortunately, there appears no simple solution to this issue. It seems highly unlikely that this radiation is solely responsible for cigarette-related lung cancer. However, it is possible that some contributory effect, either additive or synergistic, is occurring with the other cigarette toxins. This concept is strongly supported by the positive correlation between areas in lung tissue with the highest radioactive deposits and the most frequent sites of cigarette smoke-induced bronchogenic cancer. Perhaps the radioactive particles act in an initiatory fashion so as to weaken an area of tissue, thus making it more sensitive to other cigarette carcinogens.

Before the tumorigenic nature of this radiation can be fully evaluated, the actual long-term radiation dose to the cigarette smoker demands further investigation. The crucial factor, absent from prior studies but necessary in order to ascertain more accurate estimates, is the amount of time the radioactive particles spend in the lung. Since prolonged low dose uniform alpha particle exposure is capable of carcinogenicity, the residency time of Po-210 in the bronchial tree (especially at bifurcation "hot spots") needs to be more accurately determined.

At this point in time, many issues must still be resolved. With the possibility of a chronic smoker (1½-2 packs per day) receiving radiation doses up to 20 RADs in 25 years (or 267 to 534 chest X-rays per year), research into the dangers of cigarette smoke radiation needs to be continued. In the meantime, some measures can be implemented in order to reduce the radiation hazards. Although the question of limiting alpha particle flow with cigarette filters remains unanswered, research into upgrading filter systems is a valid option. Since tobacco is the main vehicle for the radiation, steps to decrease its radon daughter concentration could be attempted. This might be accomplished by using tobacco-plant hybrids (without the sticky glandular hairs) that are less efficient at trapping atmospheric radiation, or by converting to fertilizers with minimal concentrations of radioactivity.

This problem is not merely a concern to smokers but quite reasonably, to non-smokers as well. The current trend to eliminate cigarette smoking from public areas may not be simply a question of one population inconveniencing another. The possibility exists that the non-smoking population's exposure to cigarette smoke radiation is more than a trivial matter. However, we must first concentrate on defining the degree of the hazard incurred from radiation by the smoking community.

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LOUIS Z. GORDON, MD, Cincinnati; Wayne State University School of Medicine, Detroit, Michigan, 1936; age 76; died December 2, 1986; member OSMA and AMA.

EDWARD D. HUDACK, MD, Cleveland; Case Western Reserve University School of Medicine, 1943; age 81; died November 25, 1986; member OSMA and AMA.

ROBERT K. JONES, MD, Cincinnati; Howard University College of Medicine, Washington, D.C., 1931; age 83; died November 20, 1986; member OSMA and AMA.

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MARTIN R. LORENZEN, MD, Green Valley, Arizona; Ohio State University College of Medicine, 1917; age 94; died October 27, 1986; member OSMA and AMA.

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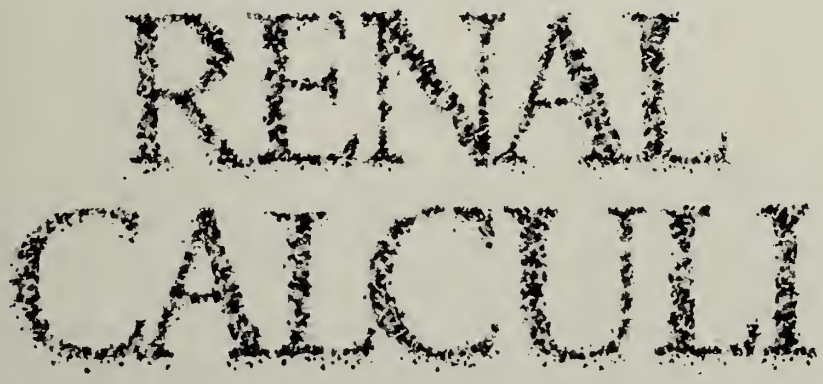
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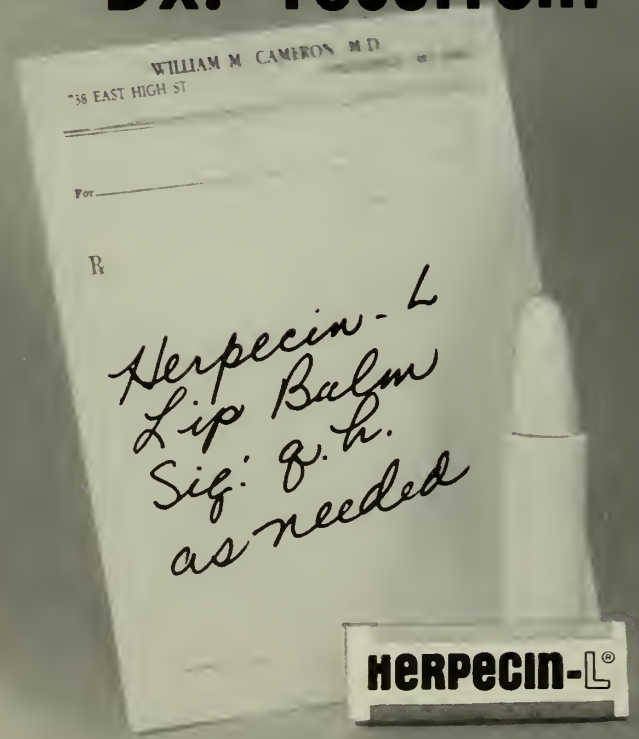
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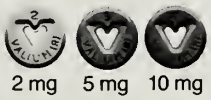
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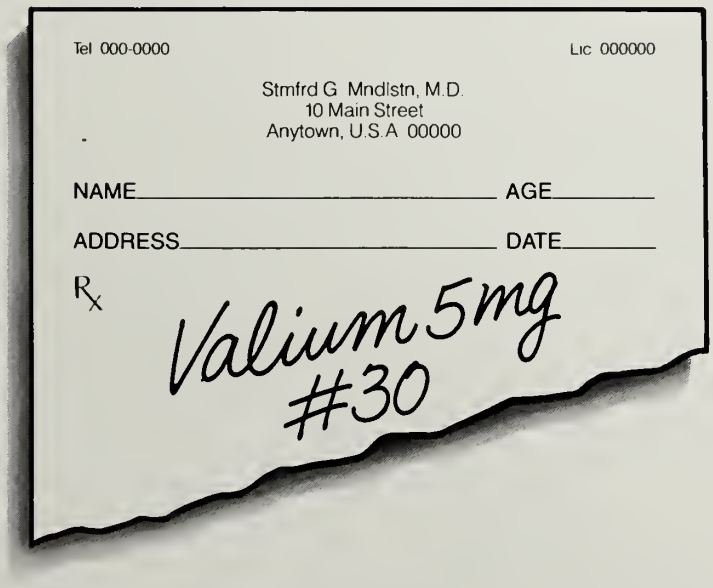
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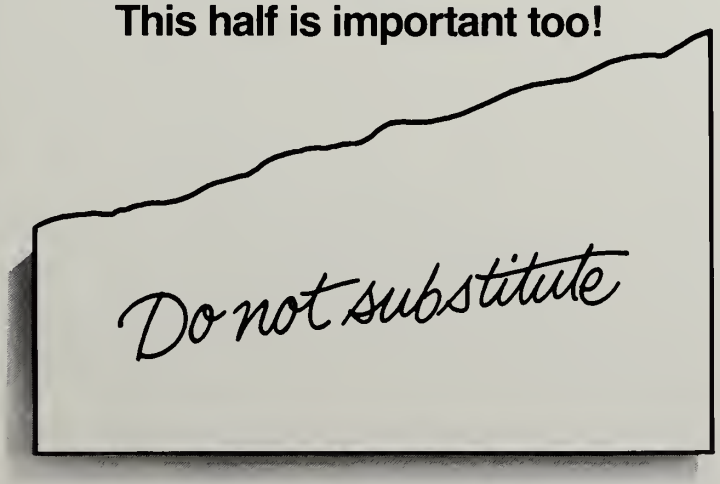
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FROM THE EDITOR

Teenagers and Medicine —

If you think the young man on our cover looks a bit uncomfortable, then you get the picture.

For years, adolescents have never quite fit into the medical scene. Too old for the pediatrician and not quite old enough for specialists and generalists who are more accustomed to older, adult patients, adolescents have dealt with their unique physical and emotional problems as best they could.

Ten years ago, however, a new specialty emerged which focused its attention on these "in-between" patients. Although slow to catch on, adolescent medicine has recently begun to gain support from both the medical community and the community at large. The American Medical Association, for example, has already issued a "white paper" on this subject and is likely to be test marketing a public education program on adolescent medicine later this year. "Ohio will probably be one of five states selected for the test," says the AMA, so it is not purely by coincidence or chance that we have decided to focus our attention this month on the subject.

Associate Editor Susan Porter begins with a look at the history of this new specialty, then proceeds to define one of the specialty's major problems — teenage pregnancy. Ohio is no better — or worse — than other states as far as the magnitude of this problem is concerned, but a Task Force on Teenage Pregnancy appointed by the Governor has recently made us more aware of this rapidly increasing problem. Perhaps its recommendations, however, will help lead us toward a solution.

Another article takes a look at "Teenage Stress" — what causes it, what it's doing to our adolescent population, and what can be done to alleviate it.

Also in this issue . . . our "Ohio Medi-scene" section describes two very interesting areas of research which are being done in this state, as well as an update on the "eye care project" which was begun late last year by ophthalmologists who were concerned with giving the needy elderly proper eye examinations. You'll also find in this issue the interim report from the AMA meeting and a foreshadowing of OSMA's own Annual Meeting — a couple of resolutions which affect the OSMA constitution.

Next month, of course, is our Annual Meeting Program issue. Don't miss it!

Karen S. Edwards

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JOURNAL COVER:

This month's cover was photographed by freelance artist-photographer Larry Hamill.

We wish to express our appreciation to Louis J.R. Goorey, MD, who allowed us to photograph our cover in his Columbus office, and to our models (l. to r.) Dana Paulus, Matt Jauchius, and Mandy Jauchius.

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Assuring quality medical education has always been a concern of the American Medical Association and one of the main reasons for its foundation in 1847. Initially, the education of physicians was haphazard and, with no standardization of schools and no formulized curricula, much was done by preceptorships. Multiple types of schools were founded: eclectic, homeopathic, herbal, proprietary schools, mail order diplomas and some self-educated individuals all declaring ability to practice medicine.

Prior to the founding of Johns Hopkins University School of Medicine in 1893, the concept of American medical education was derived from that of the 19th century German universities, hospital teaching in the British system and preceptorship in American colonial and frontier societies. Johns Hopkins School was able to combine the best of these three elements along with high standards of student admissions and faculty credentials into a quality medical school.

In 1905 the Council on Medical Education of the AMA carefully considered the Hopkins' curriculum and developed its statements of minimal and ethical standards for all medical schools. Over the next five years these standards were revised, enlarged and developed into increasingly vigorous educational criteria resulting in the first "Essentials of an Acceptable Medical College." Over the next 41 years the essentials were revised eight times to be superseded "Functions and Structures of a Medical School" in 1952. These functions and structures have been revised several times with the last revision in 1985. The latter revisions were arrived at jointly by the Council on Medical Education of the AMA and the Association of American Medical Colleges.

Early exposure of the medical students to the practicalities of medicine and the emphasis on quality clinical facilities distinguishes an American medical education from those in other countries.

The AMA has long relied on a program of on-site accrediting visits to evaluate medical school curricula. The first on-site visit of all 162 existing medical schools was performed by the Council on Medical Education of the AMA in 1906-07. In 1910 the second visits were conducted of 131 schools and from this came the outstanding Flexner Report. In 1942 the Council on Medical Education joined with the Association of American Medical Colleges (AAMC) to form the Liaison Committee on Medical Education (LCME) to continue accreditation of schools on a joint basis.

The LCME consists of six members representing the AMA's Council on Medical Education, six representing the AAMC, one Canadian member and two public members.

Ad Hoc site survey teams appointed by the secretaries of LCME conduct regular surveys of the educational programs at 20-30 medical schools every year. Schools are required to submit self-study reports to the team two-to-three months in advance of the site visit. These reports are reviewed by the four-member site team who then makes a three-to-four day visit to the institution interviewing department heads, faculty members, and student groups, and examining the curriculum, physical facilities and financial status.

The findings of the survey team are written into a confidential report containing a description of the school's resources and programs, observations on strengths and weaknesses, suggestions for improvements, and recommendations regarding the accreditation of the institution's educational program. The report is reviewed for comment by reviewers of the Council on Medical Education and the AAMC and then submitted to the LCME for action.

The LCME can 1) remove accreditation (rarely done), 2) place the institution on probation until deficiencies are corrected, 3) grant full accreditation for short, intermediate, or long-term (up to 10 years) with follow-up reports required addressing problems or potential problems as noted by the site team.

This is a condensed presentation on the history and mechanics of accreditation of American and Canadian medical schools. Since its inception, the AMA has insisted on quality medical education to protect the safety, health and welfare of the public.

John E. Albers, MD
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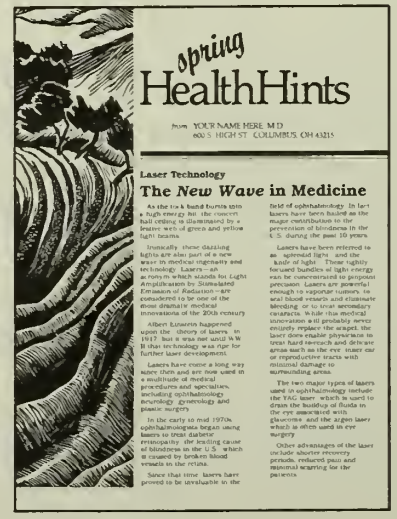
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LETTERS TO THE EDITOR

For and about Leon Goldman

To the Editor:

I am glad to inform Dr. Leon Goldman that I was "enchanted" by his Letter to the Editor, commenting on my little article entitled "Gorbachaev's Brain."

I would concur that this is, in all probability, a superficial lesion of the port wine stain variety, but I must sadly inform Dr. Goldman that, for someone who must travel on a yearly basis to the Soviet Union and function within their health care delivery system, I find that they are fully capable of handling such lesions with laser technology. I am surprised that Dr. Goldman, who seems to be so experienced in laser technology, is unaware of the Russian developments in this new area.

Sincerely,
Robert J. White, MD, PhD
Cleveland

To the Editor:

I think your editor's bio of Dr. Leon Goldman (*OSM Journal,* December, 1986) was inadequate. To describe Dr. Goldman as "knowledgeable" about port wine stain is akin to calling the Grand Canyon a hole in the ground. Dr. Goldman is universally recognized as the father of laser applications to medicine and surgery. He is one of the world leaders in the field of laser treatment of vascular abnormalities. His invitation to Mr. Gorbachaev was made quite seriously, and frankly, Mr. Gorbachaev should feel honored.

One final tangential remark. It is of interest that in none of the many photographs published in Pravda ("Truth") is Mr. Gorbachaev's port wine stain visible. Apparently, airbrushing has been elevated to a high art in the Soviet Union.

Sincerely,
Leonard Singer, MD
Cincinnati

Editor's Note: The biography of Dr. Goldman which followed his Letter to the Editor was contributed by Dr. Goldman himself.

"The Legal Basis of Malpractice Suits" clarified

To the Editor:

I read with interest the article which appeared in the December, 1986 issue of the *Journal* entitled "The Legal Basis of Malpractice Suits" by V. Franklin Colon, MD. I believe Dr. Colon should be commended for his effort to advise physicians of the history and background of the American tort system which underlie suits asserting medical claims.

However, I would like to point out that Dr. Colon has overlooked a provision of Ohio law in his discussion of lawsuits against physicians that assert claims that a physician has failed to deliver "promised" results of medical care or treatment.

In his article, Dr. Colon states that a suit may be brought against a physician on a theory of failure to deliver a "promised" result whether or not the physician's promises are in writing. Although Dr. Colon's statement may have been true prior to 1975, since 1975 there has existed an express Ohio statutory provision to the contrary.

As a part of the medical malpractice reforms enacted in Amended Substitute House Bill 682 (effective July 28, 1975), an addition was made to the Ohio Statute of Frauds, Revised Code 1335.05, as follows:

> "No action shall be brought to charge a person licensed by Chapter 4731 of the Revised Code to practice medicine or surgery, osteopathic medicine or surgery, podiatric medicine and surgery in this state, upon any promise or agreement relating to a medical prognosis unless the promise or agreement is in writing and signed by the party to be charged therewith."

In other words, a suit cannot be brought against a physician on the basis of a claim that the physician has promised a result, unless the physician has placed the "promise" in writing, and the physician has signed the document.

Yours sincerely,
William M. Todd,
Counsel to the OSMA on Professional Liability
Porter, Wright, Morris & Arthur
Columbus

Physician unions . . . the time may never be ripe

To the Editor:

In response to Dr. Gracilla's article "Is the Time Ripe for a Doctor's Union?" (*OSM Journal,* December, 1986), I have the following comments:

Physicians are not helpless passengers watching the boats go by. Many physicians are involved at all levels of HMOs, hospitals, PPOs, IPAs, and other third party mechanisms of control. The largest third party of all, the U.S. government, is not controlled by physicians. The Congress, the Executive, and the court systems are all kept constantly aware of physicians' needs and demands for quality care fairly compensated. The AMA and local societies serve as an economic and political force far more powerful in public influence than any number of unions.

The reason for our power is clear and simple. It is the ethical base of professionalism which underlies all of our medical efforts, ie., our commitment to the primacy of the individual patient. If we give up our advocacy for our patients, and for the public health, and substitute that with a union model of advocacy of economic

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J-6138 January 1986

and personal gain issues, we have lost our perspective and our professionalism.

Yes, a union might serve for short-term economic gain, but the loss of professionalism and public advocacy might be irretrievable.

Sincerely,
William T. Paul, MD
Columbus

DRGs and quality care

To the Editor:

I am writing in reference to an article which appeared in the *OSMAgram* dated September 15, 1986, entitled "Survey: DRGs Affect Quality." My objection is that the report abstracted only said that the "Medicare Prospective Payment System has altered standards of care." The title said that "DRGs affect quality." Essentially, the article indicated that as a result of the new prospective payment system with DRGs, there has been a shift of care given to the patient, especially from inpatient to outpatient treatment as the most significant. Hospitals, in an effort to cut costs, have requested that laboratory work, ancillary studies (ie., x-rays, ECGs, etc.) be reduced. Whether this has affected quality of care has not been shown and remains to be seen. There are anecdotal stories about patients prematurely discharged resulting in less than desired results. It is important to note that with the present DRG system the hospital receives a fixed payment for the specific DRG (diagnosis code). This was derived from studies which based the payment on an average length of stay. Hospitals are using the average length stay as a target date for discharge. In effect, all of those patients sent home before or at the "trim point" are within the length of stay average. So, if all patients are discharged prior to or at the point of the average, then obviously there will be financial gain to the institution. It is critical for physicians to realize that *we* discharge patients, not the hospital. Nowhere in the regulations does it appear that physicians are required to discharge patients "when the DRG days are used up"; there is no such term. It is incumbent upon us to discharge patients when ready. However, since there is a difference of opinion among physicians as to when this date occurs, Utilization Review Committees, our peers, act to help in the decision making. The Utilization Review Committee should not be a function of the hospital administration, but the medical staff. It should not function to discharge patients early simply because the hospital has requested. It is important to note that almost all hospitals have not lost under the DRG system; as a matter of fact, they have been profitable.

Think back over the past 30 years and recall the many changes. It was not too long ago when a patient with a coronary stayed in the hospital for six weeks after being in bed for two weeks. It is not unusual now to go home after several days when stable and to allow recovery at home with ambulation. Think in terms of cataract surgery, where until recently they remained in the hospital for several days and even before that with restricted bed rest, immobility, etc.; now they are outpatients. It is yet to be shown that there has been an increase in eye complications with the shift to outpatient surgery. How about hernias; years prior, the patient was hospitalized for over a week and remained in bed almost that entire period of time. Now it is not unusual for the patient to be done as an outpatient and certainly to go home within a day of surgery. I recall an older physician telling me that at the time of World War II he was

continued on page 203

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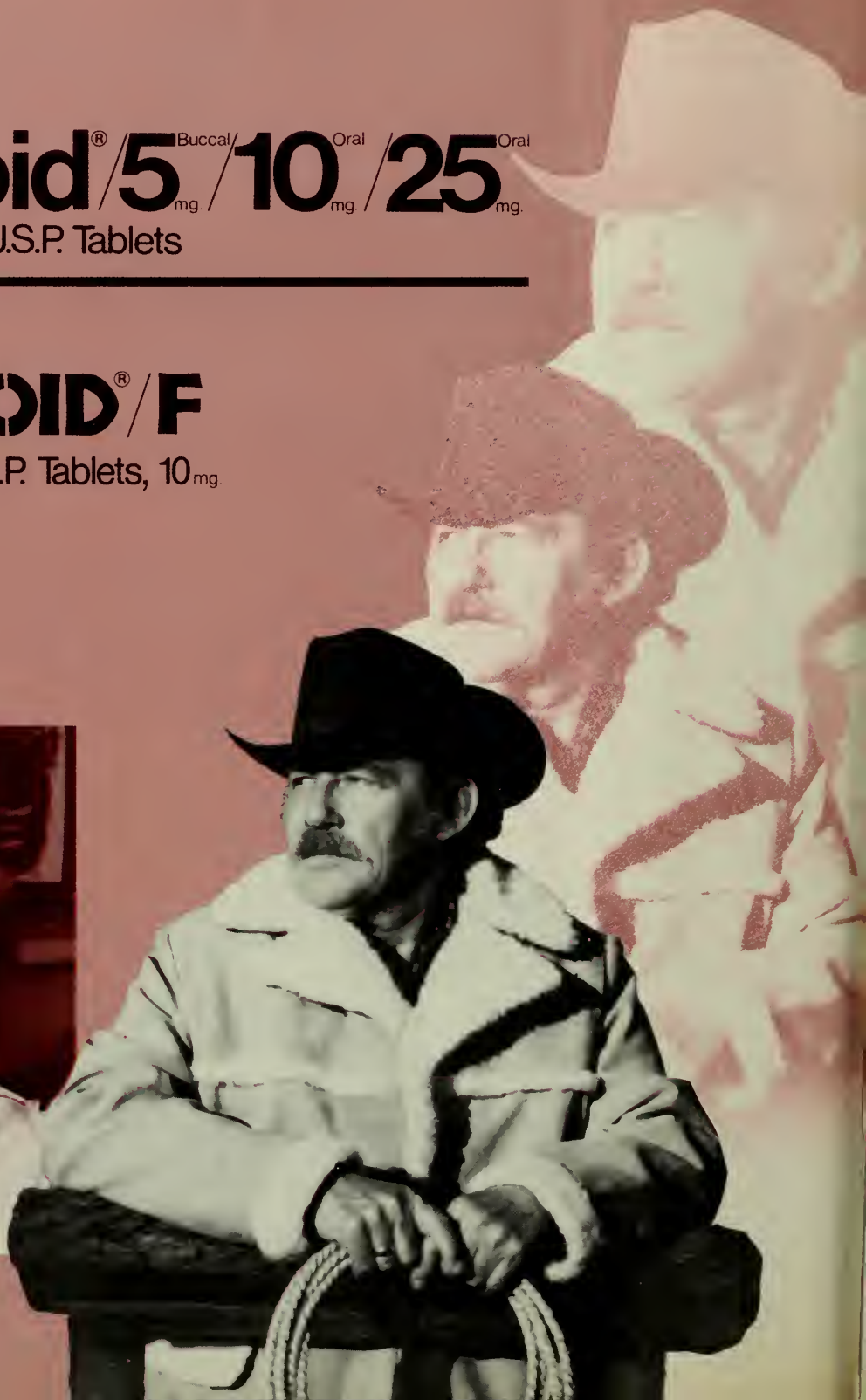
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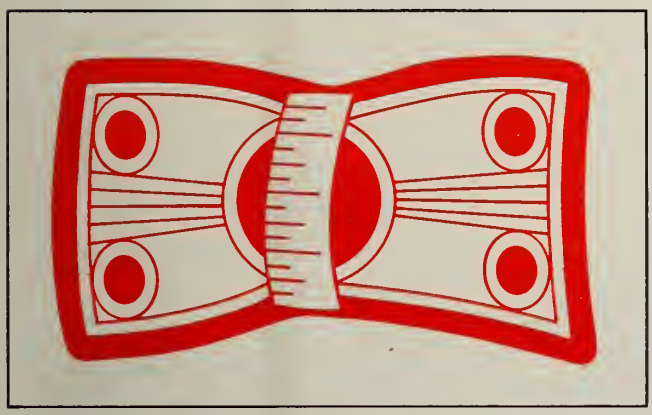
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The Health Care Dollar

George D. Clouse, MD

Three odd situations presented to me in *one* day that seemed to be noteworthy.

The first was a 35-year-old female who desperately wanted to have a baby. She had gone to a clinic specializing in infertility. Numerous tests were made, costing many hundreds of dollars. Nothing unusual was found wrong. Then the clinic focused on her husband whose tests showed him to have a very low sperm count. The clinic informed her that she had a 10% chance of being selected for artificial insemination which would cost $6,000.

She retorted that if they increased her percentage and lowered their fee she would go for it. A good answer, but the clinic was unyielding. Is this charging whatever the traffic would bear? How much should it cost to impregnate a woman?

The second case was a 33-year-old female with substernal pain who went to one of our great medical centers. My records show that several months previously I had seen her and diagnosed chest wall pain secondary to esophagitis. I recommended, among other things, a diet without spices. When at the great medical center the EKG, blood gases, and chest x-ray and other tests were normal, they then wanted to catheterize her heart. She refused fortunately, but the emergency room couldn't get it out of their heads that her doctor was a cardiologist by the same homonymous name, therefore she *must* have heart trouble. She admitted to me the next day that she had eaten some tacos and the attack came after that. How invasive can we get?

As the increasing fight for turf and health care dollars continues, physicians are still at the cutting edge . . .

The third case was a woman who said that one of the proliferating clinics called her to say that her 13-year-old daughter had a fractured wrist and should be brought in immediately! The odd thing was that the mother said she had taken her daughter to this clinic seven months ago. The only redeeming feature was that the fracture was diagnosed correctly at her first visit and she had been referred to an orthopedic surgeon who applied a cast and there was complete healing. This is an overkill of communications.

As the increasing fight for turf and health care dollars continues, physicians are still at the cutting edge. It would be wise not to allow supermarket principles to override the time-honored need for prudence, caution and common sense. **OSMA**

George D. Clouse, MD is a family practitioner in Columbus.

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of Ohio Medicine *or the Ohio State Medical Association.*
Do you have a cause you would like to support? A grievance you wish to air? Why not write a "Second Opinion"? Send your contribution to: The Executive Editor, Ohio Medicine, 600 S. High St., Columbus, Ohio 43215.

OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians.

Failure to diagnose cases

Allegations of failure to diagnose account for some 50% of malpractice claims against family physicians, a spokesperson for the American Academy of Family Physicians' task force on professional liability reported in *Medical World News.*

The three major areas of diagnostic failure are cancer, abdominal conditions, and fractures, with breast cancer being most responsible for legal suits against physicians.

"The single biggest mistake in this country in the early diagnosis of breast cancer is accepting a negative mammogram as evidence that cancer is not present, especially when a palpable mass is there," said the academy's past chairman Holger Rasmussen, MD.

Suggestions in the article for minimizing the chance of legal action include good follow-up, continuity of care, good communication with patients and colleagues, involving patients in the decision-making, and keeping good medical records.

Ice advice

How do you spell relief for headaches?

F-R-E-E-Z-E-R, says Chicago headache specialist Seymour Diamond, MD, in a recent issue of *Medical World News.*

Dr. Diamond said that 80% of his patients who, in addition to their medication, placed an ice pack across their foreheads reported immediate relief from their headaches.

Commercial gel packs win out over plain ice because they last longer and don't irritate the skin, he added.

Tobacco vice

First the Ohio State Medical Association, and now the American Medical Association wants to send a message to Don Johnson and other celebrities who light up on screen — "put an end to your lung vice."

WIDE WORLD PHOTOS



"Miami Vice" star Don Johnson.

At the OSMA Annual Meeting last year, substitute resolution number 35-86 was passed which called for a tobacco-free society by the year 2000. Although nothing in that resolution was pointed, specifically, to the entertainment industry, that situation was rectified shortly after the meeting, when Council recommended the Ohio Delegation take a resolution, calling for the entertainment industry to de-emphasize smoking, both on the big *and* little screen, to the AMA interim meeting.

At the AMA meeting, which occurred late last year (for a more complete story, see "The AMA Interim Report" elsewhere in this issue), the Ohio Delegation duly introduced Resolution 24 — Smoking and the Entertainment Industry. The resolution, which was amended slightly before being passed, reads as follows: RESOLVED, That the American Medical Association encourage the entertainment industry to continue to de-emphasize the role of smoking on television and in the movies.

The anti-tobacco message also extends to the use of smokeless tobacco by professional athletes.

Hepatitis vaccines

Physicians, health care professionals and high-risk individuals should be immunized against hepatitis B, according to recommendations made at a recent interim meeting of the American Medical Association (AMA).

Medical schools should also adopt a program of hepatitis B immunization for medical students before they begin their clinical training, the AMA delegates added.

Other AMA recommendations included:

* To encourage third-party payers to provide immunization coverage for adults.
* To urge physicians to advocate immunizations for adult patients, to provide vaccines for ambulatory patients as well as hospital patients, and to keep complete immunization records.
* To urge the Civilian Health and Medical Program of the Uniformed Services to provide vaccine coverage for dependents.

Edited by Deborah Athy

Doctors purchasing power dips again

According to a survey published late last year by *Medical Economics* magazine, office-based physicians are continuing to lose purchasing power, despite an average 6.0 percent boost in fees.

The median practice net, for example, was up only $550, or .5 percent — the smallest gain ever recorded in the publication's continuing survey of practice income. Although professional expenses hit new highs (including a 31 percent boost in malpractice insurance premiums), the difficulty seemed to lie with earnings rather than expenses.

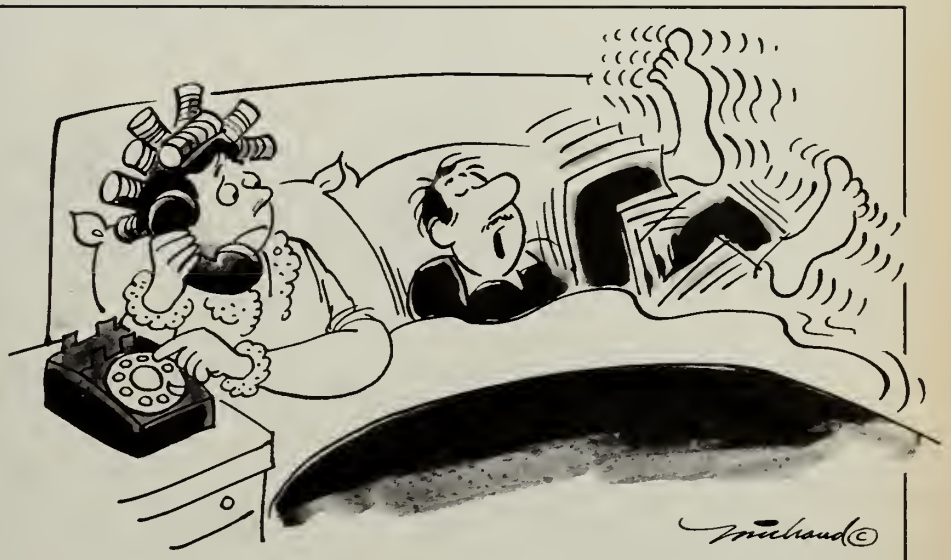
The top ten practice earners for 1985, however, were:

1. Neurosurgeons
2. Orthopedic surgeons
3. Plastic surgeons
4. Thoracic surgeons
5. Radiologists
6. Anesthesiologists
7. OBG specialists
8. General surgeons
9. Internists
10. Psychiatrists

Former Journal editor dies

R. Gordon Moore, former editor of the *Ohio State Medical Journal,* died from a heart attack December 2, 1986. He joined the *Journal* staff in 1948 as assistant managing editor and assistant business manager, and retired as the *Journal*'s executive editor in October, 1974.

Moore was a graduate of the Louisiana State University School of Journalism, and had experience in daily and weekly newspapers before joining the *Journal* staff.



"Aging sleep" can be a nightmare

If your elderly patients complain frequently about the quality of their sleep, don't be surprised.

According to David J. Kupfer, MD, Professor and Chairman of the Department of Psychiatry at the University of Pittsburgh, sleep, like other body functions, "ages" right along with the individual — often becoming lighter, more erratic and fragile as the person grows older.

This can result in sleep disorders, says Dr. Kupfer — like sleep apnea, where the patient awakens, literally gasping for breath, or nocturnal myoclonus, a restless sleep, frequently accompanied by leg kicking.

Insomnia is another common complaint among the elderly — with an estimated 90 percent of all Americans between 60 and 80 experiencing either chronic or occasional sleeplessness.

But "aging sleep" can be coped with, says Dr. Kupfer. Here are some tips on how your patients over 60 can help themselves get a good night's rest:

- Instruct them to maintain regular daytime and nightime schedules. The body's cues to sleep and waken are not as acute as they were in early adulthood.
- Tell them to sleep in a dark, temperate room.
- They should avoid caffeine, alcohol and nicotine after 4 pm. And, finally,
- If sleep doesn't come, tell them not to worry about it. Instead, they should get out of bed, read a book, write a letter — in short, relax. Sleep will come eventually.

Advising your patients to skip the afternoon nap and engage in more physical activity is also a good idea. And remember, a sudden change in lifestyle — like retirement — is bound to affect sleeping patterns, at least short-term, so don't forget to take that into consideration . . . and perhaps warn your patients accordingly.

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OHIO MEDI-SCENE

New perinatal institute . . . lead study underway . . . dining in Summit County . . . Medicaid tips . . . ophthalmologists treat the elderly.



Perinatal Institute on the move

In August 1986, the University of Cincinnati and Children's Hospital Medical Center collaborated in a unique effort to open new doors to perinatal research in Ohio and in the country.

These efforts gave rise to the Perinatal Research Institute, an interdisciplinary collection of investigators researching key issues in perinatal medicine. While, as yet, no *actual* doors have been opened — that is, the institute is not housed in a separate facility, but is dispersed between UC and Children's Hospital clinical labs — the *concept* has enjoyed "some sort of permanency, because of the support of both hospitals and an opportunity to attract topnotch investigators," explains Reginald Tsang, MD, Director of Neonatology at both hospitals.

Bringing together some 20 to 30 researchers from such diverse disciplines as bioengineering, gastroenterology, molecular biology, obstetrics, endocrinology, and neonatology, the Institute is composed of "one of the largest, if not the largest, clusters of researchers in the perinatal field in the world," says Dr. Tsang. The wide range of specialties enables the Institute to perceive the same problems from different vantage points, he adds.

Since its inception, the Institute has received four major grants from the National Institutes of Health for research into various facets of perinatal research, including studies of diabetes and pregnancy and intrauterine growth retardation, as well as funding for researchers and the use of clinical facilities at both hospital medical centers. Some researchers were also funded by outside grant agencies.

Creating and substaining the Institute has been a "huge effort and enterprise," Dr. Tsang relates. Government, industry and private funding and support is essential to keep the scientific excellence intact. In addition to research monies, the Institute has been receiving government assistance from a national scientific advisory committee.

The Institute is composed of one of the largest . . . clusters of researchers in the perinatal field in the world.

OHIO MEDI-SCENE

Perinatal Institute . . . *continued*

Some of the Institute's current investigative endeavors include pursuits into:

***Molecular biology.** Researchers are looking at ways to apply molecular genetic techniques in order to prevent prenatal problems and to improve survival rates for critical fetal and newborn infants. Leading investigators in pulmonary development are "on the verge of eliminating respiratory distress syndrome" by working to regulate the production of surfactant — the substance which prevents lung collapse, the dominant factor in syndrome situations, explains Dr. Tsang.

***Perinatal nutrition.** "After you save the baby, you must find how best to care for the baby," Dr. Tsang says. Researchers are working to develop optimal nutritional and support guidelines to safeguard high-risk infants during this critical period. A key focus is how to adequately and safely provide nutrients. The Institute is the "leading center in the country for calcium-related problems," he adds.

***Fetal physiology.** Researchers are investigating fetal and newborn metabolism, endocrine systems and physiology to minimize the possibility of handicap and to increase infant survival. "The best time to prevent problems is as early as possible," Dr. Tsang emphasizes.

***Bioengineering and computer work.** The Institute is working with the UC electrical engineering program to create optimal environments for premature infants. Researchers have developed the first computer-regulated, temperature-controlled incubator system for extremely low birth weight infants which has proven to reduce infant mortality, Dr. Tsang says. "The next decade will see a lot of computer work," he adds.

Already, tremendous advances in perinatal medicine have been realized, says Dr. Tsang. While approximately 11 of 100 babies are born premature, an estimated 90% of these babies (at the Perinatal Institute) will survive, he points out.

But Dr. Tsang foresees many more exciting innovations taking shape in the next decade. "We hope to have a solid organization of the best collection of perinatal researchers in the world and to encourage others to open similar institutes," he says.

By this time, he continues, respiratory distress syndrome will be wiped out; perinatal nutrition will be very finely tuned — sugar and calcium intake, for example, will be "amenable to computer application"; and fetal surgery as an intervention will be fairly commonplace.

"We don't have the foggiest idea at this moment how exactly these things will come about, but I can dream of ways," he says. "We're allowed to dream, I hope."

— *Deborah Athy*



UC lead study underway

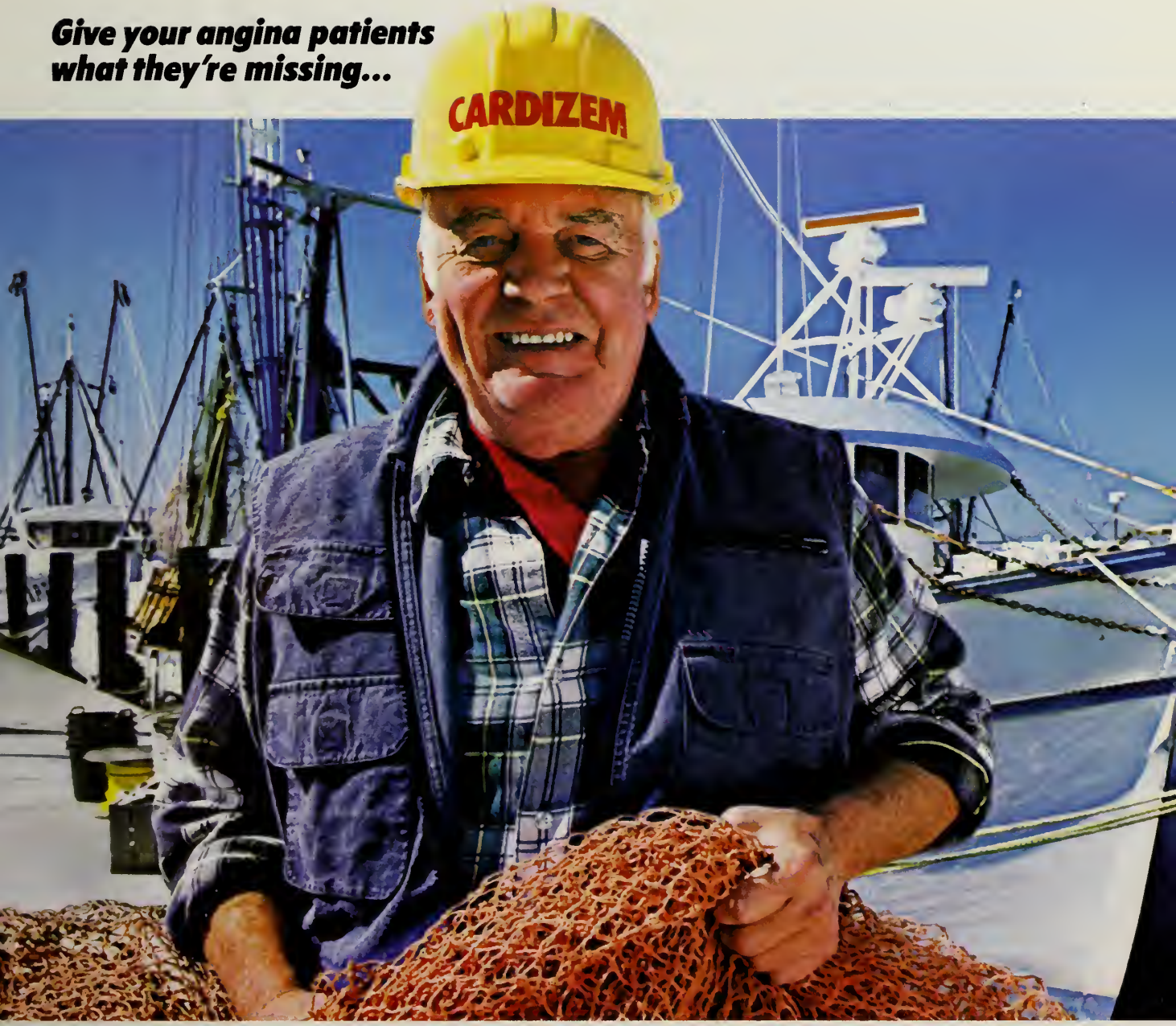
Can exposure to lead — even in small amounts — found in housing materials, dust, soil and old paint impair a child's behavioral development?

That's what researchers from the University of Cincinnati's Kettering Lab are investigating in an ongoing study of over 300 inner-city Cincinnati children.

"The primary goal is to determine the health effects of low to moderate lead exposure in infants and young children," reports Kim Dietrich, PhD, developmental psychologist for the study.

Research on this subject has been conducted before, most recently by a team of U.S. Environmental Protection Agency (EPA) investigators who, for the first time, reported a link between lead exposure and subtle hearing losses in the general population. An EPA spokesperson reported that children exposed to even low levels of lead suffer hearing losses

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CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS

General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes, however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 7/86

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References: ***1.*** *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers. Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983, 106(6):1341-1347.* ***2.*** *Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984,24(Dec):150-159.* ***3.*** *Johnston DL, Lesoway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985,55:680-687.* ***4.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***5.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982,50(Sept):94-116.*

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which can affect their ability to understand speech.

But the UC study is unique in that Dietrich and his colleagues are *repeatedly* tracking lead levels in the children — beginning by measuring lead levels in the mothers' blood during pregnancy and continuing by tracking these levels in the children as they develop. "We take an assessment of lead exposures quite regularly, which is unprecedented," says Dr. Dietrich, explaining that the EPA study results were based on one measure of lead exposure per child.

Because Dietrich and his colleagues are tracking and correlating measurements of lead to the mental and motor development of the children every three months, the UC study will be the most comprehensive study of its kind and will provide a more definitive confirmation of the EPA study with good supporting histories, Dr. Dietrich says.

The study got rolling in 1980 after the National Health Organization went over existing studies on lead exposure and found them lacking in methodology. The organization then called for "prospective" studies in this area, which would begin prenatally and continue as the children progressed in school. The National Institutes of Environmental Health Sciences subsequently appealed for research proposals. The medical college in Cincinnati, having a history of research in toxicity and in biological aspects of lead exposure, received funding for the project.

While the study will continue through 1991, preliminary studies have found that "prenatal exposure can result in poorer behavioral development in the first six months of life, including slower hand-eye coordination, vocalizing, imitation, visual and auditory tracking, and alertness," says Dr. Dietrich. Lead exposure has also been linked to lower birth weight and shorter gestation, he adds.

Of particular interest is the fact that these levels of lead exposure are rather low — "below the levels of concern outlined by the Centers for Disease Control," he points out. "We are detecting health effects from very low levels of exposure that are typical in any urban community."

Automobile exhaust from unleaded gasoline has traditionally been cited as one source of environmental lead. The EPA study also pinpointed lead found in drinking water due to lead-soldered pipes as another source.

But the UC researchers are looking primarily at the home as the key source of lead exposure in their study. Cincinnati has a large older-home stock, explains Dr. Dietrich — an abundance of pre-WW II homes in various stages of disrepair, with lead dust, chipping paint, etc.

So, while there is not a lead-related problem with the drinking water in Cincinnati, according to current standards, there *is* a fair amount of house-related lead, he explains.



Dining in

Summit County Medical Society has recently added a new 2600 square foot Memorial Dining Room to its meeting hall facilities at 440 Grant Street, Akron.

Nine booths line the sides of the dining room and accommodate four persons each. Each booth is dedicated to an outstanding physician, either living or deceased, who contributed significantly to the medical society. The dining room's eight tables and 16 lounge chairs will be similarly dedicated.

The dining room will seat between 100 and 120 for dinner, and the adjacent meeting room with theater-style seating, will accommodate up to 100. A dry bar, movie screen and sound system (which interlocks with the sound system from the dining room) are additional features of the meeting room, while a warming kitchen and lavatories enhance the new dining facilities.

Both the meeting room and the new dining room were built with revenue raised from the services offered by the Summit County Medical Services Bureau. — *Sidney H. Mountcastle, Executive Director, Summit County Medical Society.*

OHIO MEDI-SCENE

UC lead study

. . . continued

One question the researchers are considering is whether the mothers in the study — who may also have been exposed to lead when they were growing up — pass on lead exposure to their children during pregnancy, though this is still under speculation.

Children are generally more susceptible to lead exposure and lead poisoning than adults, Dr. Dietrich says. This is especially true in the prenatal stage when fetuses are in a sensitive stage of development.

Studies to date also suggest that male infants are more sensitive to lead effects than females — a finding Dr. Dietrich says is not all that surprising, considering that "premature males are more sensitive to perinatal insults in general." However, he points out

ne question being nsidered: whether mothers ss on lead exposure to eir children.

that this doesn't mean females aren't affected by lead exposure; they just appear to be less affected than males. Males are physically and physiologically less mature at birth, he says. "There may be genetic reasons for the male disadvantage at birth given adverse conditions."

While still in its infancy, Dr. Dietrich has high hopes that in time the UC study will be considered "the definitive study of lead exposure . . . internationally." — *Deborah Athy*

Medicaid tips

The Ohio Department of Human Services makes quarterly changes in the Medicaid Drug Formulary. Presently the updates are February 1, May 1, August 1 and November 1.

Most additions and all deletions are based upon recommendations presented by the Pharmacy and Therapeutics Committee. The committee is composed of Janet Bixel, MD; Charles May, DO; James Visconti, PhD; Suzanne Eastman, RPh, MS; Mary Ann Waltenbaugh, RN; and Robert Reid, RPh, Chairman.

At the September 1986 P & T Committee meeting the following issues were resolved which will have an impact on the February 1, 1987 update.

*** Put a MAC (Maximum Allowable Cost) on the generics of Aldoril 15 and 25 (Methyldopa/HCTZ), Sinequan and Adapin 75mg (Doxepin), Bentyl 20mg (Dicyclomine), Deltasone and Meticorten (Prednisone), Haldol Conc Soln (Haloperidol), Lasix injectables (Furosemide), Mycostatin & Nilstat Oral Susp (Nystatin), and Zyloprim 100mg (Allopurinol). Allopurinol 300mg was not MAC'd because one or more manufacturers are still using an FD&C Dye #6 that could conceivably cause allergic problems. Sinequan 150mg will also be removed since it will be less costly to prescribe 2x75 mg generic.

*** For cost effectiveness add the generics of Symmetrel (Amantadine), Motrin 800 (Ibuprofen), Meclomen (Meclofenamate), Aldoril D (Methyldopa/HCTZ 500/30 and 500/50), Triavil and Etrafon (Perphenazine/Amitriptyline), Desyrel (Trazodone), Calan and Isoptin (Verapamil), Proloprim 200mg (Trimethoprim), Nitroglycerin Patches, Haldol 20 mg (Haloperidol), and Reglan (Metoclopramide). Metoclopramide is being readded since the generics now have all the indications that the innovator brand has.

***Many new drugs were added to the formulary February 1, 1987. If a new drug is on the market but not on the formulary, it is either because the manufacturer did not submit a request, the submitted request was denied, or the release date was after late October '86. A minimum of 71 days lead time is necessary for legislative filing procedures required to change formulary content. New entries into the formulary 2-1-87 include Alupent 5% in 30ml, Biltricide, Codeine Phosphate tabs, Colyte, Gastrolyte, Grisactin Ultra 330, Gyne Lotrimin 500mg, Humulin BR, Insulatard NPH Insulin, Intron A, K-Dur, Lupron 4 week kit, Marinol, Nephro caps, Niclocide, Novolin 70/30, Procardia 20mg, Roferon A, Rufen 800, Tagamet Viaflex, Tavist Syrup, Vancoled 500mg, Velosulin Human Insulin, Vesprin tabs and inj, and Zydone. Buspar will also be added.

*** The generic listing of Prenatal 1 + 1 will be removed since Stuartnatal 1 + 1 reformulated and the generics as yet have not. Merital will be deleted since it is no longer available. Otherwise the deletions will be limited to those aforementioned in the MAC determinations. — *Robert Reid, pharmacist, Columbus; Janet A. Bixel, MD, Columbus.*

Crackdown on cancer

By the year 2000 the National Cancer Institute wants to cut the number of annual cancer deaths in half (an estimated 462,000 Americans died of cancer in 1985).

To pare down this figure, the institute plans for stepped-up efforts against cigarette smoking and a greater emphasis on diet, cancer prevention, screening, early detection and treatment.

Other elements of the institute's strategy against cancer include:

- To reduce the amount of fat in diets to less than 30% of total calories.
- To increase from 15% to 80% the number of women age 50 to 70 who undergo breast exams and X-ray mammography.

Self-help guide for the elderly

The National Institute on Aging has published a directory entitled *Self-Care and Self-Help Groups for the Elderly.* The directory provides details about organizations which deal with the concerns of older people or have programs relevant to older people, their families and the health professionals who work with them.

If you would like to have this guide available as a reference source for your elderly patients, you may obtain a copy free of charge by contacting the NIA Information Center/SCSH, 2209 Distribution Circle, Silver Spring, MD 20910, or by calling (301) 495-3455.

3,911 Call Ohio Helpline: Eye physicians treat blinding diseases

Potentially blinding eye disease can be treated effectively if detected early, a fact that 3,911 elderly Ohio residents have discovered through the National Eye Care Project (NECP).

Volunteer Ohio ophthalmologists have uncovered:

535 cases of cataracts,
49 cases of glaucoma,
115 cases of macular degeneration,
and 22 cases of diabetic retinopathy,

among elderly Ohio residents who have called the toll-free Helpline — 1-800-222-EYES (3937) — to receive assistance through the NECP.

The public service, which offers medical eye care to the disadvantaged elderly at no out-of-pocket cost, is sponsored by the Ohio Ophthalmological Society and the Foundation of the American Academy of Ophthalmology.

The NECP is available to U.S. citizens or legal residents, age 65 or over, who are not currently under the care of an ophthalmologist, and who have not seen one within the past three years.

Since the Ohio Helpline opened on May 5, more than **3,911** residents have called, resulting in more than **2,622** referrals of elderly patients to local volunteer eye physicians for medical examination and possible treatment for sight-threatening eye diseases. More than 140,000 elderly Americans have called the toll-free Helpline number — 1-800-222-EYES — since the project opened in January.



Amazingly, about 34 percent of those examined by ophthalmologists report that they had *never* before had a comprehensive medical eye examination. For another 20 percent, it had been more than five years since their last eye

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Eye physicians treat blinding diseases . . . *continued*

examination.

"We want elderly people to know that failing eyesight in their later years can be prevented or lessened through early diagnosis and treatment," said Bruce R. Paxton, MD, president of the Ohio Ophthalmological Society.

After calling the toll-free Helpline, an elderly person will be mailed the name of a volunteer ophthalmologist who will treat the patient, regardless of his or her ability to pay, and who will accept (for this project) Medicare or insurance assignment as payment in full. If hospital care is needed, the ophthalmologist will work with a local hospital to make care available. Hospital charges, eyeglasses and prescription drugs are not paid through the program.

More than 7,000 ophthalmologists are participating in the NECP. The Helpline is open weekdays from 8 am to 5 pm in all states (except Hawaii, 8 am to 3 pm).

Under 40 and feeling fine

Did Dr. Watson ever join Sherlock in partaking of a little snuff? Perhaps if he were still around today — and if he were under 40 — chances are that he may have.

According to a Harvard University School of Public Health survey, almost 40% of physicians under age 40 say they have tried marijuana or cocaine.

The survey polled 500 physicians and 504 medical students from Massachusetts. More than half the physicians and 75% of the med students admitted to using some type of drugs to get high, stay awake or for self-treatment. Only 1% said drug use ever caused patients to receive poor care.

Whether the survey is representative of the nation's young doctors as a whole is unknown. However, the survey *is* timely, considering Florida Medical Association's pending resolution which urges physicians to take a leadership role in combating the nation's drug habit by undergoing voluntary drug testing.

1-800-282-7502

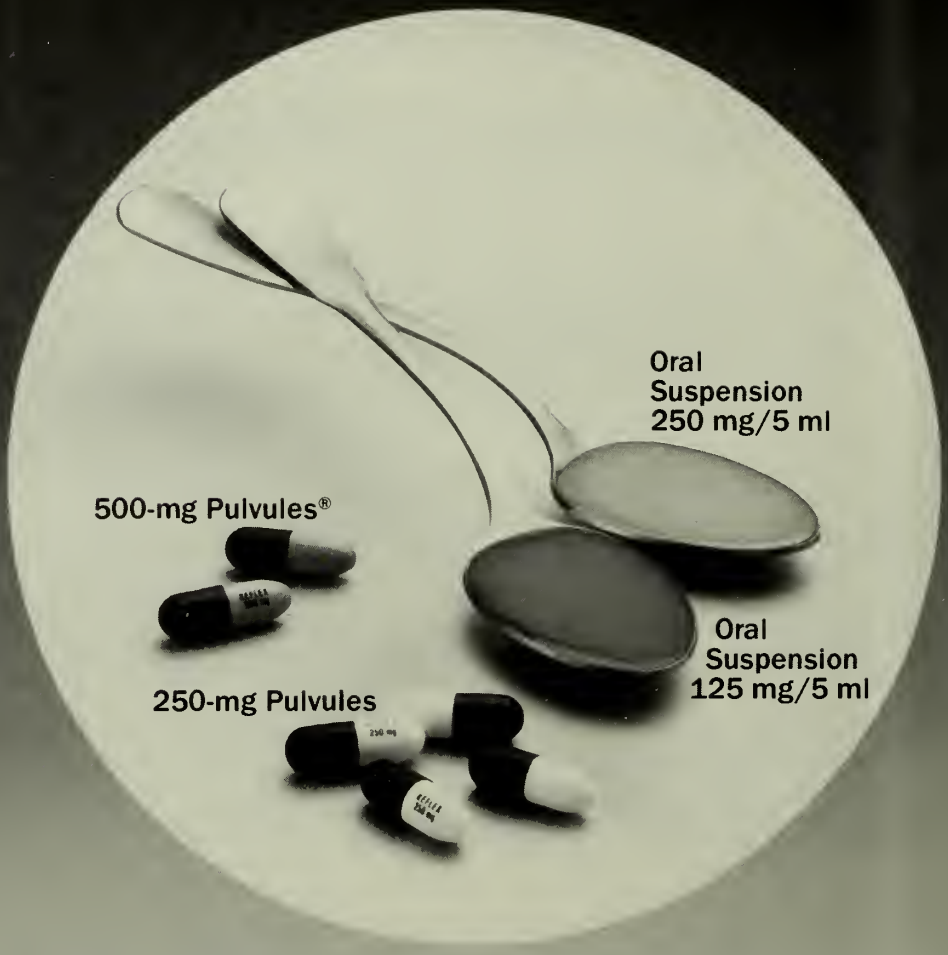
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Is There a Place for the Adolescent Patient?

By Susan Porter

Adolescence. It is a period of tremendous human growth, development and confusion — that stage in life where nothing in the world seems impossible, with the exception of getting rid of a giant pimple before Saturday night. Trapped in a limbo between childhood and maturity, the individual going through that second decade in life is bombarded with a series of physical, psychological and social changes that can make life difficult not only for the teen but for everyone around him or her.

"Outside of infancy, adolescence is the time of most rapid growth and development for both males and females," says H. Verdain Barnes, MD, Chairman of the Department of Medicine and Professor of Medicine and Pediatrics at the Wright State University School of Medicine in Dayton. Health care problems commonly seen in teenagers range from allergies and acne to pregnancy and sexually transmitted disease, says Dr. Barnes, a former president of the Society of Adolescent Medicine and the first Wyeth Professor of Medicine, a designation given him last year by the National Society for Adolescent Medicine. While chronic diseases that begin in childhood — sickle cell anemia, Crohn's disease and diabetes, to name a few — become compounded at this stage, adolescence can mark the beginning of many new problems: hypertension, mononucleosis, skin diseases and a variety of orthopedic and gynecological disorders.

"In addition to physical growth and sexual maturation, there is psycho-social growth and development," adds Dr. Barnes, as the newly emerging adult attempts to break away from old ties and relationships and to form new ones. Suddenly, parents and other adults drop in status, and peers take on a new influence — creating a variety of conflicts at home, at school and elsewhere in the community.

The physician's office is not immune from such conflicts. Little Johnny may have been a model patient as a five-year-old, but as a teenager, he may be aloof, uncomfortable and uncooperative. Not only has he outgrown the child-sized chairs in the pediatrician's waiting room — he has also outgrown his relationship with the doctor whom he still sees as his parents' advocate.

Perhaps this is why a significant number of the nation's youth go through puberty without ever

"Normal teen behavior is to take risks and to feel immortal. There is a sense of invulnerability which is a part of the adolescent mindset."



seeing a physician. According to a recent American Medical Association White Paper on Adolescent Health, "Despite all the identified hazards of their transitional stage in life, persons in this age group do not use physician services as frequently as do other population groups; in fact, recent government data show that adolescents have the lowest rate of physician office visits of any age group.

"This low utilization rate, however, does not necessarily indicate that adolescents have the lowest rate of illness," the report continues. "On the contrary, they report a higher incidence of acute conditions than do older persons."

The reason for the adolescent's avoidance of a physician at this crucial stage in development are many, physicians who specialize in adolescent medicine from around the state agree. While a teen may feel he or she has outgrown the pediatrician's office, that same teen may feel awkward going to Mom or Dad's physician.

Added to that is the young person's embarrassment about his or her newly developing sexuality, along with feelings of invulnerability — that nothing bad can happen to him or her. "Normal teen behavior is to take risks and to feel immortal," says Fredric Rothman, MD, a Toledo pediatrician who has specialized in adolescent medicine for the past nine years. "There is a sense of invulnerability which is a part of the adolescent mindset — and this has always been with us."

The results of this type of thinking, however, are often disastrous: reckless driving, experimentation with drugs and alcohol, unwanted pregnancies, poor eating habits and other forms of irresponsible behavior which can permanently affect the young person's life and health. Today this aspect is particularly crucial, says Dr. Rothman, because society, as a whole, seems to have shirked many of its responsibilities and at times seems bent on a course of recklessness and impulsiveness.

On the other hand, adolescence is a stage of great potential — a period when lifetime habits are being formed and important decisions are being made which will affect the individual's happiness and health for years to come. Unlike children who still lack independence and autonomy, teenagers are able to assume much of the responsibility for themselves and their own good health, says Richard Weinberger, MD, a family physician from Beachwood who frequently deals with teens in his practice. Yet unlike adults, "adolescents are both malleable and vulnerable," says Dr. Weinberger. "Adults with problems tend to resist change," he says, while "most teenagers are very treatable and willing to change their habits."

Thus the adolescent years are a key time for learning and adopting healthy habits: good nutrition, safe driving skills, constructive methods for handling stress and other preventive measures that could save them from future health care problems. And physicians dealing with teens must be prepared to

Physicians dealing with teens must be prepared to help guide them through this difficult, yet potentially rewarding phase of development.

help guide them through this difficult yet potentially rewarding phase of development, recognizing the unique needs of adolescents and making a place for them in their practices.

According to Robert T. Brown, MD, director of the section for adolescent health at Children's Hospital in Columbus, the special needs of the teenage patient have been formally acknowledged by the medical community in this country for over 35 years, when J. Roswell Gallagher, MD, set up the first adolescent clinic at Boston Children's Hospital. However, adolescent medicine actually dates back to turn-of-the-century England, when physicians at residential boys schools began studying and treating the unique needs of those in this age group.

In Ohio, according to Dr. Brown, the first adolescent medicine clinic was established in Cincinnati in 1958 and was the third of its kind in this country. By 1963 there were 24 special adolescent health clinics in the U.S., and in 1968, the Society for Adolescent Medicine was founded — the same year the U.S. Department of Health, Education and Welfare began offering fellowship grants for physicians in adolescent medicine.

As a group, pediatricians were among the first to consider adolescent medicine a specialty. According to Dr. Brown, the pediatrician's emphasis on growth, development and prevention has always extended into the teenage years and more recently into early adulthood. The American Academy of Pediatrics now defines its patient group as all of those in the 0-21 age bracket, he points out.

However, some 80% of the nation's 42 million young people between the ages of 12 and 24 are cared for by general practitioners or family physicians, Dr. Barnes points out, while only 15% are still seen by pediatricians. (The remaining 5% go to internists, gynecologists and other specialists.) Thus, in 1977, the American Medical Association defined adolescent medicine as a separate specialty, although 80% of those completing fellows in this area are pediatricians, according to Marianne McGrath, MD, the former associate director of adolescent medicine at Children's Hospital Medical Center in Cincinnati.

According to Dr. McGrath, these fellowships — now offered in three Ohio locations: the University of Cincinnati, Columbus Children's Hospital and Cleveland Metropolitan General Hospital — represent pediatric's efforts to fill a gap in medical education and care. In 1978, says Dr. McGrath, the American Academy of Pediatrics Task Force on Pediatric Education issued a lengthy report listing adolescent medicine as one of three areas in need of further attention and training by practicing pediatricians. (The other two areas were child psychiatry and developmental pediatrics.)

Most of those pediatricians who go on to obtain fellowships in adolescent medicine, however, remain in the academic arena, she points out, because there is a tremendous shortage of trained and experienced instructors. Two-thirds of the pediatric departments in the major medical schools still have no experts in that area, according to Dr. McGrath.

"A few go through (the fellowship program) and practice general pediatrics, with the ability to contribute their knowledge about adolescent medicine to a group practice," says Dr. McGrath, who at the end of 1986 left Children's Hospital Medical Center in Cincinnati to open a private practice in adolescent medicine. "But it is very difficult to practice pediatrics and adolescent medicine at the same time," she adds.

In fact, treating teens in general can be difficult for a number of reasons, she and others relate. Aside from some legal problems that can be encountered when treating minors without the consent of their parents (see related sidebar), there is the issue of fees. Because both pediatricians and family physicians tend to charge fees "at the low end of the scale for office visits," according to Dr. McGrath, it frequently is not cost effective to spend long periods of time discussing social and emotional problems with teens in conjunction with physical problems — although these are often interrelated. "Most of the time physicians who see adolescents are frustrated that they can't spend more time dealing with the 'hidden agendas' adolescents sometimes present," Dr. McGrath comments.

Daniel Krowchuck, MD, a

"If one is going to take care of teens, he or she may have to have a willingness to forego adequate remuneration."

pediatrician specializing in adolescent medicine at Cleveland Metropolitan General Hospital, is even more specific about the financial problems physicians in private practice can encounter when they treat large numbers of adolescent patients. For example, says Dr. Krowchuck, Ohio law allows teens to be treated for sexually transmitted diseases on a confidential basis — without the knowledge or consent of their parents. However, it does not address how physicians are to be reimbursed for examinations, lab tests and treatment procedures, since "parents don't have to pay for care that they don't authorize."

In addition, says Dr. Krowchuck, "The extra counseling and explanation time teens require can create a great deal of problems" for the physician who is seeing a large number of patients. "There is no good answer to this problem," he says. "If one is going to take care of teens, he or she may have to have a willingness to forego adequate remuneration" in a number of cases.

An option, says Dr. McGrath, is to charge fees according to length of time instead of on a per visit basis. Because she spends 60% of her time counseling teens, and the other 40% with more routine office care, she uses a combined billing system. The counseling time is billed on an hourly basis, she says, while routine care is billed for in a traditional per-visit manner.

Due to financial considerations, most adolescent clinics in existence today are associated with hospitals and/or are government supported. At Cleveland Metropolitan General, for example, three separate clinics are aimed at indigent teens in the community: a general adolescent medicine clinic where teens can come with a variety of health care problems; a reproduction health program, where sexuality and attendant consequences (pregnancy, venereal diseases, etc.) are dealt with; and a medical program for teen parents and infants, rendering medical and social aid for those in this group.

Still, there is much a physician in pediatrics, general practice, family practice, internal medicine, gynecology or any other specialty can do to help meet the unique needs of teens in his or her community — without opening up a special adolescent practice. By following some basic guidelines, physicians in any specialty can tailor their practices to patients in this age group, assuring them of quality health care both now and for years to come.

SOME TIPS ON TREATING THE ADOLESCENT PATIENT

1. Establish a setting that is comfortable to adolescents. Whether you're a pediatrician, a family physician, or a general practitioner with a number of teens in your practice, you have to provide an environment that is comfortable to this age group. "You don't need to pipe in rock music in order to do this," says Dr. Brown, "but a setting for older kids — with chairs larger than a foot high — is essential." Posters and pictures which express the feelings and concerns of young people are also important, and literature on problems common to teens can also attract their interest.

In some cases, it may be necessary to set aside a special waiting room for teens — or to establish a certain day or time of the week to see teens only. This eliminates the situation where an awkward teen is forced to sit between a new mother with a crying infant and a five-year-old with the measles.

2. Establish an "adult" relationship with the adolescent patient. You may have been treating Johnny all of his life — but the adolescent years are a time of tremendous change, those in this field point out, so you will have to change your relationship with him. Issues of separation and independence are key developmental steps in moving from childhood to adulthood, according to Dr. Weinberger. Thus it is important that the physician make a visible effort to treat the patient like an adult and to help him or her become responsible for good health care practices.

This can be done by encouraging the teen to schedule his/her own appointments, by talking privately with the teen, and by examining the teen patient alone, without a parent present.

3. Assure the patient of confidentiality. While adults expect confidentiality from a physician, it is natural for an adolescent patient to fear that his or her parents will be informed of all of the details of

While adults expect confidentiality from a physician, it is natural for an adolescent patient to fear that his or her parents will be informed . . .

a medical exam or consultation. However, in order for teens to openly share their health care problems with a physician — particularly those surrounding sexuality issues and substance abuse — they must be assured of strict confidentiality.

4. Keep parents apprised of the teenager's health status. Confidentiality, however, does not mean that parents should be ignored. Rather, parents should be kept up-to-date on the teen's overall health status and should also be talked to individually — on a confidential basis — about the problems they may be having as parents. Physicians should encourage teens and parents to talk about issues of moral concern, says Dr. Barnes, who adds, "It's a rarity to have an adolescent who eventually is not willing to discuss a problem with the parent or to sit with me while I discuss it with the parent — with the teen's permission." In such discussions, however, says Dr. Barnes, it should remain clear that the physician is the advocate of the patient — not the parent.

5. Become familiar with health care problems common in teens. According to the AMA White Paper on Adolescent Health, two-thirds of American youth try an illicit drug before they finish high school, nearly half of all teens are sexually active, and more than a third of adolescents' visits to physicians involve somatic complaints. Some 18% of adolescents suffer crippling or other health impairments, including visual, hearing, speech and other physical handicaps, while 16% suffer from emotional disturbances. Excluding violence and accidents, cancer is the leading cause of adolescent death.

A physician who deals with teenagers must be familiar with the types of problems they experience and must be prepared to screen patients for disorders common in this age group. In addition to the above, adolescents should be screened carefully for scoliosis, slipped capital femoral epiphysis, Osgood-Schlatter disease, hypertension, idiopathic male gynecomastia, and other disorders, says Dr. Barnes, founder and editor of the *Journal of Adolescent Health Care* which attempts to keep physicians up-to-date on these and other health care problems.

6. Be prepared to bring up sensitive issues. Sexual activity, drug and alcohol use, contraception, obesity, acne — all are extremely sensitive issues, and most teens, along with some physicians, are embarrassed to bring them up. But in most cases, it is up to the physician to broach these topics with the adolescent patient, so if you're not comfortable discussing these, you probably should refer the patient to another physician.

On the other hand, the shy or reticent teenager is frequently greatly relieved once these topics come out in the open, says Ralph E. Kah, MD, an obstetrician/gynecologist from Middletown who sees some teens in his practice. "If you show teens you're interested and can talk about sensitive issues,



"If you show teens you're interested and can talk about sensitive issues, they will be very candid with you. Many actually breathe a sigh of relief."

they will be very candid with you. Many of them actually breathe a sigh of relief when you bring it up."

7. Be familiar with other resources in your community. Dealing with adolescents who have a wide variety of problems can be tough, so that, on occasion, the aid of others in the community may have to be called upon. "This is definitely an area that requires a multi-disciplinary approach to problems," Dr. Brown points out. Thus, it behooves the physician to become familiar with drug and alcohol rehabilitation programs, family planning clinics, etc. that may be of help to teens. "A physician may need to go outside the standard medical referrals and to open up new contacts outside the medical community in order to address these problems," says Dr. Brown.

8. Take advantage of school physicals and other routine visits to bring up potential problems. Because most teenagers are relatively healthy, many do not see a physician for years at a time. Therefore, physicians should take advantage of any sports checkups, school physical exams, etc. to inquire about other difficulties teens may be having — either emotionally or physically. This can generally be accomplished by asking some simple questions, such as "How are things going at home and at school?" or "Are you having any problems with drugs?" Booklets and pamphlets on contraception, sexually transmitted diseases, etc. can also be left in the waiting or examining room or distributed to the patient who appears to be having some problems.

9. View the problem through the teen's eyes. A mild case of acne or a sudden weight gain may not present major health problems to the adolescent — but in the teen's eyes, minor problems often seem critical. Thus, says Dr. Barnes, physicians should take the teen's concerns seriously and give them adequate attention. "You have to view these problems from the perspective of their importance to the individual, rather than purely from a medical viewpoint," he says. In this way, the emerging adult will learn to trust the physician with his/her problems and will continue to seek help when more serious problems come along.

10. Don't be too judgmental. "Dealing with teenagers can be wild and hairy," Dr. Rothman warns. "Frequently you are dealing with sex, drugs and violence — and now, self starvation. It's not always pleasant."

With so many of today's teens involved in premarital sex, alcohol abuse and drug abuse, it may be difficult for a physician coming from a more conservative point of view to relate to adolescents. Yet in order to help those in trouble, physicians who specialize in this area agree, it is important that a doctor not be too judgmental or critical. Teenagers are particularly sensitive to criticism at this stage and are more in need of a friend than a lecture when they run into health care problems.

"As parents, most of us, if asked, hope and pray that our children will choose not to be sexually active," says Dr. McGrath. "But at the same time, we realize that our children are not ourselves — that they are separate individuals with choices to make — and they don't always make the choices we wish they would."

By providing teens with accurate information about contraception, pregnancy, sexuality, nutrition, drug and alcohol abuse and other health care problems, physicians can help adolescents make wiser decisions as they strive to reach adulthood and a new level of maturity. **OSMA**

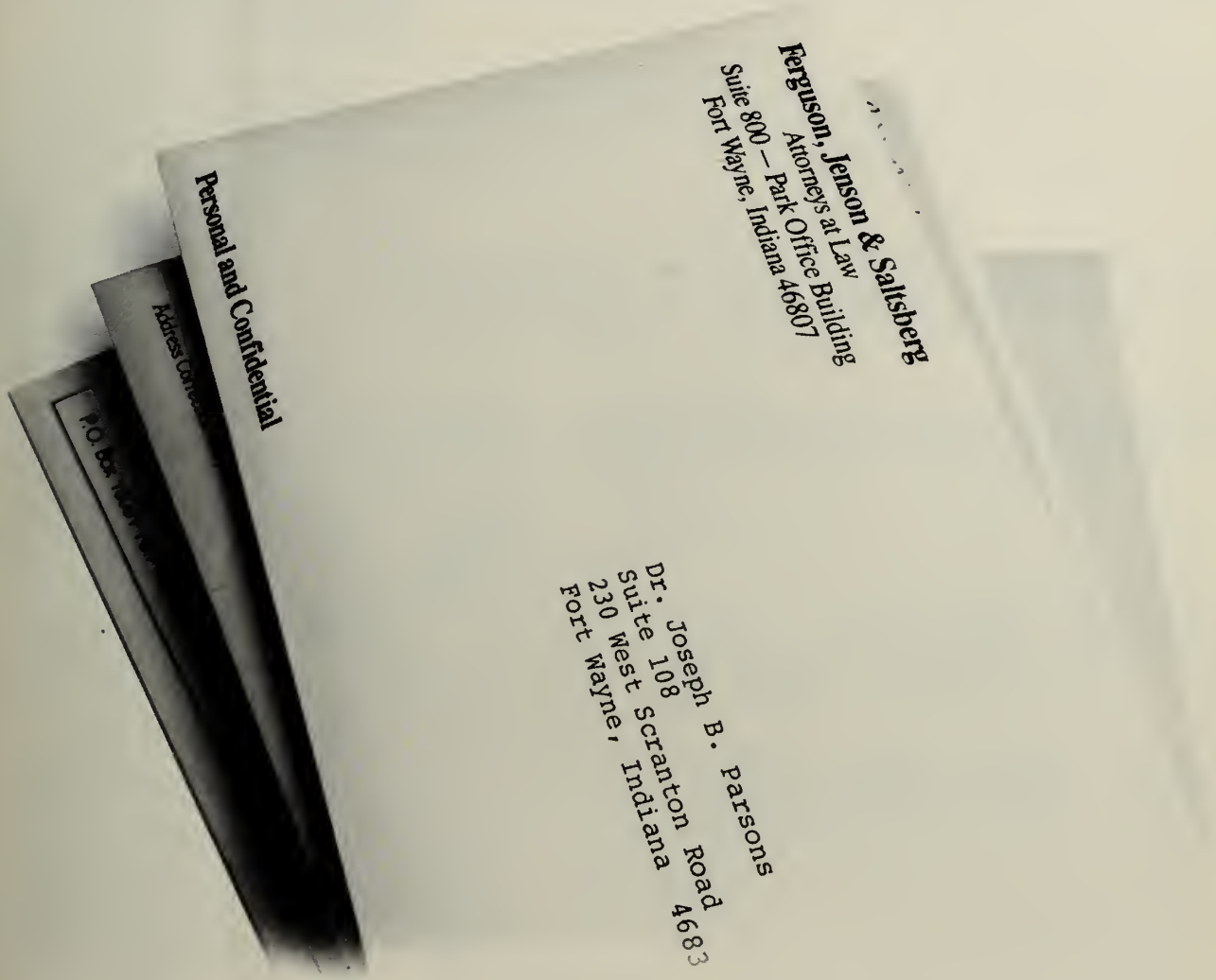
Susan Porter is the Associate Editor of **Ohio Medicine.**

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Sexuality and Pregnancy: A Change in Values

By Susan Porter

Twenty years ago, the subject was quietly and politely avoided. With little notice, a teenage girl unfortunate enough to get "in trouble" would be whisked from school, not to be seen again for several months. Then, just as discreetly, she would reappear amidst whispers and raised eyebrows, never to mention the infant son or daughter born in the interim.

But times have changed. Today, twice as many young women have had sexual intercourse by the age of 16 as did in the mid-1960s, says a special report issued on teenage pregnancy by the State of Ohio, Governor's Task Force on Adolescent Sexuality and Pregnancy. The majority of those who get pregnant today are encouraged to stay in school and complete their educations — an effort to curtail the 60% of the teenage mothers in Ohio who eventually become dependent on welfare. Some girls actually bring their babies to school and show them off to envious friends — much as elementary children bring a doll to school on occasion.

Said one teenager interviewed in a recent American Medical Association teleconference on adolescent health, "It's real fashionable in some circles to get pregnant."

On the other hand, nearly one-quarter of all Ohio teenage pregnancies end in induced abortions, according to the Task Force report. Of those teens who do give birth, 95% to 97% choose to keep their babies. Often the infants are raised at home by their grandparents, while their teenage mother goes on about her business.

Thus, the embarrassment and shame associated with getting pregnant out of wedlock — once a major deterrent to sexual promiscuity among teens — has all but disappeared. Not only is teenage pregnancy and motherhood openly admitted and in some instances flaunted as a kind of status symbol among high school girls — it is also bragged about by boys.

According to one physician from a small town in Ohio, "Boys like to espouse fatherhood openly as well." One popular teenage football player, he relates, recently was quoted in the school yearbook as saying that "becoming a father" was the highlight of his senior year. "Rumor has it he got more than one girl pregnant," this doctor relates.

If the attitude isn't shocking,

"I walk through the Neonatal Intensive Care Nursery on some days, half the infants I see are from adolescent pregnancies . . ."

the statistics are.

"More than half of America's teenagers report having had sexual intercourse by their 17th year," says a December 1986 Louis Harris and Associates poll commissioned by the Planned Parenthood Federation of America, Inc.

"The mean age of first intercourse is less than 15 years," according to an AMA White Paper on Adolescent Health issued in January.

"Approximately one million or 10% of all American teenage girls become pregnant each year," says the Governor's Task Force report.

"One-third of all abortions are obtained by adolescents," says the AMA's White Paper.

On the other hand, only one-third of all sexually active teenage girls uses birth control, according to the AMA teleconference.

Add to all of this the increasing incidence of sexually transmitted diseases among adolescents; the high incidence of low birth weight, birth defects and death among infants born to teens; and the inherent difficulties in children raising — or not raising — their children, and the problems cannot be ignored. Teenage sex and pregnancy are creating health care problems of major magnitude in the adolescent population and have equally serious implications for society at large.

"The problem of adolescent pregnancy is a national disgrace," says Reginald C. Tsang, MD, in a guest editorial in the January 1987 issue of *Focus On,* a monthly publication of the University of Cincinnati Medical Center. "When I walk through the Neonatal Intensive Care Nursery on some days, half the infants I see are from adolescent pregnancies. Death and severe disabilities are some of the consequences of adolescent pregnancies."

In addition, Dr. Tsang points out, more than 20 sexually transmitted diseases are now seen in adolescents, while "a paper in the *Journal of Pediatrics* describes sexually active adolescent girls who have an average of six infective organisms in the lower genital tract relating to later reproductive problems, ectopic pregnancy and infertility." The solution, he believes, is "widespread, intensive education to our young people about adolescent pregnancy and its often tragic and devastating consequences of severe infant illness and death."

Yet teaching adolescents about the often unhappy consequences of an unexpected pregnancy is not easy. "Teenagers all seem to demonstrate 'magical' thinking," says J.E. Holman, MD, an obstetrician/gynecologist who treats a number of pregnant teens in the Steubenville area. "When you ask them why they don't use birth control, they shrug their shoulder. Some kids have had intercourse for over a year before they get pregnant — and they think it will never happen to them."

Another problem is the difficulty teens have getting information about contraception, sexually transmitted diseases and the numerous other ramifications associated with becoming sexually active at an early age. Many parents are uneasy discussing these issues with their teenage children — and teens are equally uncomfortable with these subjects. While in Ohio, all school systems must include some information on reproductive health and sexually transmitted diseases; this usually takes the form of an impersonal biology class covering menstruation and reproductive function at the junior or senior level — after many teens are already sexually active.

"There seems to be a real reluctance on the part of the schools to get overly involved," says Ralph E. Kah, MD, an obstetrician/gynecologist from Middletown. One reason is society's conservative stance towards the discussion of topics surrounding sex in the schools. In many cities, communities have frowned upon schools covering sexuality in the classroom — particularly if topics such as contraception and abortion are mentioned — because they feel that discussing these options is tantamount to condoning premarital sex, he says.

Yet — with or without the information — the problem continues to grow, according to Antoinette P. Eaton, MD, professor of pediatrics and preventive medicine at the Ohio State University and chairperson of the state's Task Force on Adolescent Sexuality and Pregnancy. One of the task force's six recommendations is that "the Legislature Should Mandate K-12 Human Growth and Development

"Not only sexual intercourse but information on contraception should be included in a well-rounded human development and growth course of study."



(Personal, Social, Physical and Mental) education through standards adopted by the State Board of Education." At the present time, only two states — Maryland and New Jersey — mandate that sex education be integrated at all grade levels, says Dr. Eaton.

Often communities fight sex education in the schools because "parents fear," says Dr. Eaton, "that the sex act will be discussed in kindergarten. But that's not what we mean. We're talking about teaching values, decision making and taking responsibility for what you do and don't do."

At an appropriate level, however, she adds, not only sexual intercourse but information on contraception should be included in a well-rounded human development and growth course of study.

Some parents also have problems when physicians discuss contraception with sexually active teens. Yet it is a physician's responsibility to inform adolescents about all of the risks associated with being sexually active, says Dr. Kah. "We're not talking about advocating or promoting teenage sex," he adds. "We're talking about needs. You can't change their habits, but you can help to protect them."

Occasionally parents, Dr. Kah admits, "get very irate or extremely upset" when a physician recommends or prescribes contraception for their teenage daughter or son. "But I've raised teenagers," says Dr. Kah, "and my concern would be if my daughter went to a physician requesting contraception and she was sent



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Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975, 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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2. Beaver, WT *Arch Intern Med,* 141:293-300, 1981.

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"We need to help them develop a sense of awareness, to show them they can express their new sexuality in ways other than becoming sexually active . . ."

away with a lecture — and without any information or protection," he says.

He agrees, however, that providing adequate sex education to teens involves much more than simply making contraceptives available to them. "Ninety percent of it is this business of educating them about their developing sexuality," he says. "We need to help them develop a sense of awareness, to show them they can express their new sexuality in ways other than becoming sexually active — to let them know they are allowed to say 'No.' "

While the bulk of sex education should take place in the home and schools, physicians can also get involved in the process, says James M. Bazzoli, MD, a gynecologist from Marion County, where the teenage pregnancy rate was several percentage points above the state average back in the late 1970s. There, words like "epidemic," "crisis," and "emergency" were being used to describe a situation where more than one out of five births in a county was to a teen mother.

The problem in Marion County was turned around through a number of steps, says Dr. Bazzoli. "All of our school systems have adopted K-12 programs in human awareness," he relates; although he adds, "Implementation has been better at some schools than others."

A major thrust, however, was setting up the Marion Adolescent Pregnancy Program (MAPP), a community service program which aims to prevent teen pregnancies as well as to help those teens who become pregnant. Among preventive services, says Dr. Bazzoli, who founded the program and continues to serve as the president of its board of directors, is confidential counseling on issues of concern to teens. These include information on anatomy and basic sexuality, birth control information, free pregnancy testing with results within 24 hours, referral to Planned Parenthood and VD information and referral — as well as help with support and clarification of values.

Those teens who do become pregnant in Marion County are aided by "family life educators" who not only help to assure they receive appropriate prenatal care, but also follow mother and child through the first two years after birth. Teens not only learn how to care for their infants, but also learn to become self-sufficient adults; either by going back and continuing their formal education or by finding full-time employment.

While not every physician has the time to set up such a comprehensive program, doctors can serve as a valuable community resource, Dr. Bazzoli says. "Contraception, sexuality and venereal diseases are hot topics that teachers aren't always comfortable discussing in the classroom," he says. However, physicians can act as guest speakers in sex education classes because most are "more comfortable and knowledgeable dealing with it."

Even the parents of teens may be more receptive to physicians explaining the facts of life and all of their consequences to their children, he says. "And it's much less likely that a physician will be misquoted or misunderstood, especially if he's well known in the community."

Physicians are also urged to serve on school curriculum and educational planning committees to share their expertise on adolescent sexuality and development. Like Dr. Bazzoli, they may also be in an ideal position to bring problems of teenage sex and pregnancy to the attention of community leaders. "The physician in the community can take a leadership role on this issue and serve as a local source or quotable person when these issues come up in the news," he says.

By speaking out in the classroom and in the community, physicians can also help to alert teens to the dangers involved in teenage sex and pregnancy. For example, teens age 15-19 are among those at greatest risk for gonorrhea and syphilis, says the Governor's Task Force report. "A high proportion of low birth weight infants suffer from epilepsy, cerebral palsy, deafness, and brain and spinal damage. Development is often delayed, susceptibility to disease is increased and learning disabilities are prevalent."

In addition, "infants of teen mothers are more likely to be deprived of the stimulation needed for optimum development," the task force found. "Many teens have unrealistic and inappropriate expectations about the behavior of infants which often lead to child abuse. Infants of teens are more often seen in the health care delivery system suffering from injuries due to accident."

And finally, says Dr. Bazzoli

"Children pick up social values from TV, where everyone has sex without the consequences. No one gets pregnant unless the story demands it."

and other physicians who deal with sexually active adolescents, physicians can remind the adult parents of sexually active teens about their responsibilities in making sure that both their children and grandchildren don't suffer these unfortunate consequences.

"In some ways, it seems that families have abdicated their traditional roles as healthy models for thinking and behavior," says Fredric Rothman, MD, an adolescent medicine specialist from Toledo. "The casual way kids are reared today reflects a kind of irresponsibility in society in general and a reluctance (for adults) to serve as good examples."

Too often, he says, children pick up social values from TV, "where everyone has sex without the consequences. No one ever uses birth control or gets pregnant — unless the story demands it."

Also involved, says Dr. Kah, is society's overemphasis on sexuality. Sex is thrust at young people through movies and TV, newspaper and magazine ads, and in their peer groups. Too often, he says, teens get the message that they don't have to wait to have sex.

Perhaps the AMA's White Paper on Adolescent Health sums it up best. "Caught between peer values, parental values, the image of sex portrayed in the media and their own developing value systems, adolescents frequently act impulsively, engaging in sexual intercourse without being prepared for it and thus avoiding "premeditated sex."

Until society as a whole comes to grips with this issue, it is not likely that the problems associated with adolescent sex and pregnancy will disappear in the near future.
OSMA

Susan Porter is Associate Editor of **Ohio Medicine.**

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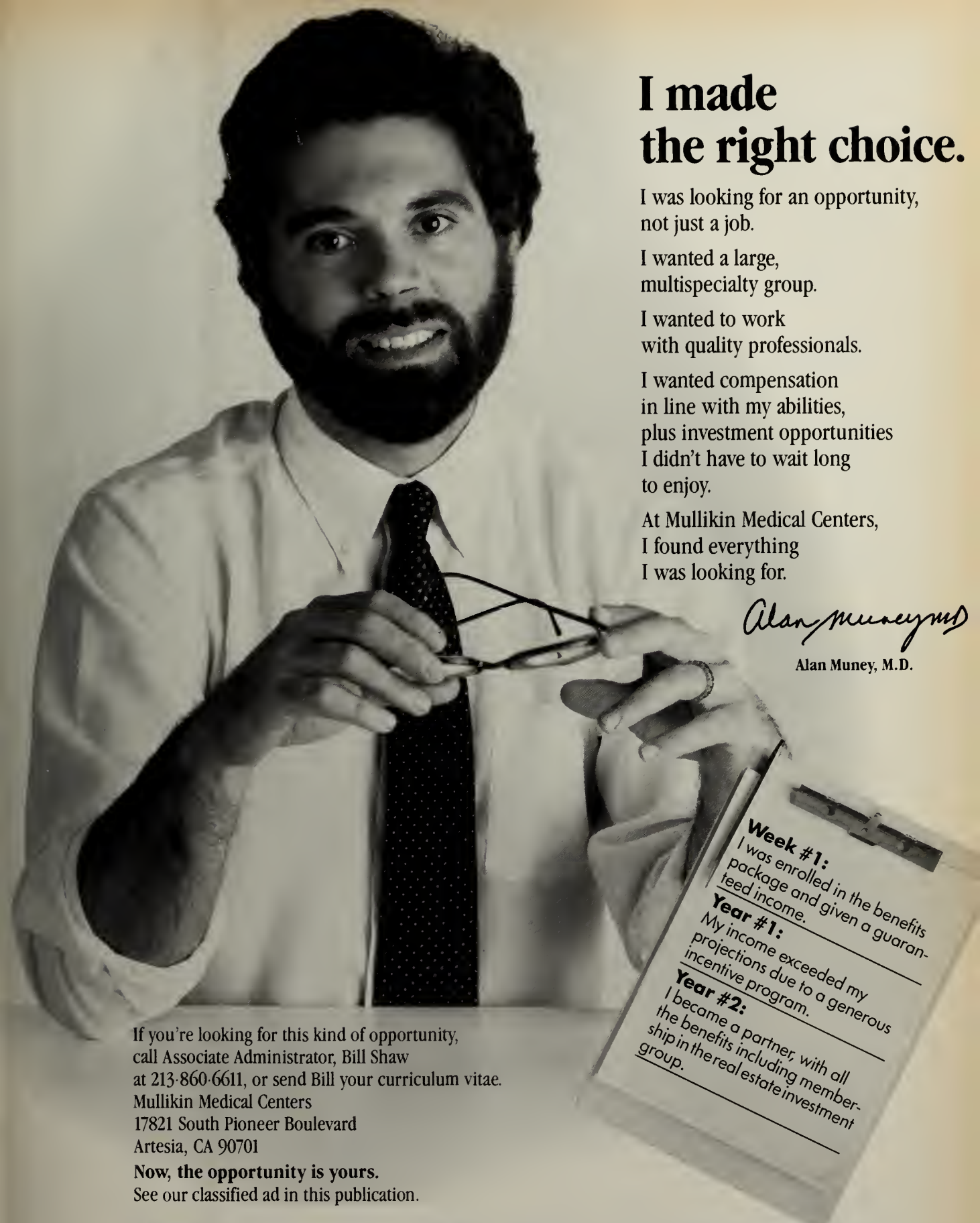
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Adolescence and Stress

Children Coping in an Adult World

By Karen S. Edwards

In the movie "Peggy Sue Got Married," a 30-plus-year-old housewife was transported (through movie magic) back in time to her adolescent years. Only *this* time around, she was able to view all the confusion and turmoil that occurs in her life through the eyes of a mature adult.

If every teenager was able to accomplish that same miracle, there would probably be little need for a specialty like adolescent medicine — but the truth is, every adolescent must endure what adults have come to, euphemistically, call "growing pains" — that stage of life that thrusts teenagers out onto a tightrope stretched between childhood and adulthood, dependence and independence. They want both, accept neither, and all the while they make discoveries about who they are and what it is they want to do with their lives. It's an exciting time, a painful time — and a time of immense physical and emotional stress, not only for adolescents, but for those around them who must endure the obligatory rebellion, the necessary "testing of the waters."

As if this rite of passage was not awkward enough, society has thrown the teenagers another curve. It has relaxed its morals, invented a pharmacy full of new drugs, and made the old ones even easier to obtain. Then, it has rocked back on its heels and smirked as parents and others in authoritative positions scramble to keep the adolescents from destroying themselves.

"Society today is more liberal," says Percy D. Mitchell, MD, Clinical Director of Dartmouth Hospital, a private mental hospital in Dayton which features a program for adolescent patients. "It has given adolescents the permission to act as adults — permission which is often reinforced by parents, as well as television."

But this early push into adulthood is not only premature, says Dr. Mitchell, it inflicts tremendous pressure on the adolescent.

"The adolescent is simply not ready to be an adult making adult decisions," says Dr. Mitchell.

The teen's lack of experience in life issues often means he or she is making unwise decisions which can lead to a brand-new set of stresses and pressures.

"Drugs, alcoholism, teenage pregnancy and so on take teens out of their normal life-cycle — and any time an adolescent is taken out of his or her normal pattern of development, it's stressful," says Roslyn Seligman, MD, a psychiatrist whose

While many teenagers encounter some degree of depression, depression in adolescents can take many forms.

Cincinnati practice includes both children and adolescents, as well as adults.

"The pregnant teenager, for example, is taken out of her natural period of growth and development for nine months — and that's nine months that's needed by the adolescent to carry on growing and maturing," says Dr. Seligman.

Small wonder, then, that the statistics on the mental health of today's teenager are less than encouraging.

Nationwide reports estimate that in the 14 to 18 age group, there are 17 million adolescents who are experiencing some type of mental or emotional problem. Of these, 20 percent (3.4 million) are mentally disturbed, and of these, only half are seen in treatment.

From this data, then, it could be logically argued that there are many more adolescents who are experiencing emotional problems — but who never present themselves, either to their parents, or to you, the physician. So, how can you properly diagnose the ones who may need help?

Most experts will tell you it's not easy.

"Adolescents are more diverse than people realize," says Dr. Seligman.

While many teenagers encounter some degree of depression, for example, depression in adolescents can take many forms.

"I had one adolescent who quit going to school. She said she just couldn't get up in the morning. I've had teenage runaways and adolescents who have expressed themselves in antisocial ways."

And this doesn't even begin to cover the full scope of emotional problems triggered in adolescents by the stresses and pressures of growing up.

"Alcoholism is still a major, major problem," says Dr. Mitchell, and neither suicide (covered extensively in the July, 1985 issue of the *OSMJ*) nor substance abuse appears to be declining in teenagers. In fact, says Dr. Mitchell, suicide and substance abuse are often interrelated.

"Two-thirds of the youngsters who have committed, or who have attempted to commit suicide, have been involved in some form of substance abuse," he says — and as often as not, these days, the substances abused are crack and coke.

"Teenage use of these drugs is increasing because society's use of these drugs as a whole is increasing," explains Dr. Mitchell — and adolescence *is* a highly imitative stage of life.

"Although they hear adults and their sports and entertainment idols saying 'do as I say, not as I do,' they have a tendency to not listen to the things we're saying, and to learn from what we do," says Dr. Mitchell.

As a result, when reports of adult use of these drugs soar, it is naturally reflected in adolescent behavior.

Eating disorders (again a subject that has been covered extensively in the *OSMJ,* see December, 1985) are often another manifestation of an emotional or mental problem suffered by an adolescent. Although the problem is usually deep-seated, some of it may be due, in part, to the adolescent's increased awareness of his or her body image.

"In adolescence, the body goes from a relatively indistinguishable form to a highly distinguishable form," says Dr. Mitchell.

As breasts develop, shoulders widen and facial and body hair begin to appear on the young adult, a body image begins to form which shapes the teenager's view of himself or herself.

"It's a self-esteem, self-confidence issue," Dr. Mitchell explains.

Yet few adolescents are ever really satisfied with the way they look, and thus new stresses and tensions are raised — fed by both the adolescent and his or her peers.

"This is the period when locker-room jokes begin to appear," says Dr. Mitchell, and the teen who may be the butt of those jokes is apt to experience some emotional difficulties, both during adolescence and on into the future.

The overweight teen is the perfect example.

"I feel sorry for the overweight adolescent," says Dr. Seligman. "They are teased so much and adolescents can be so cruel to each other."

Barbara Cromer, MD, an adolescent medicine specialist at Children's Hospital in Columbus, agrees.

"The obese adolescent suffers peer rejection, which makes it difficult for him or her to make that move from dependence to independence," she says.

Teenagers who are unable to dress in the same fashion as their peers and who are unable to participate in the same physical activities are apt to find themselves social outcasts — just at a time when being in the social circle is all-important.

And, to make matters worse, obesity is not an easy thing to treat in a teenager.

The peer group functions like a safety net for the adolescent who is out there on that tightrope between dependence and independence.

"By the time they reach the doctor, you can bet they've heard about their weight problem from every corner," says Dr. Cromer.

She brings up the subject of weight loss just once with an adolescent.

If they're interested, I put them in touch with a program — if they're not, we forget it," she says.

Of course, part of the problem with treating any obese patient — adult *or* adolescent — is attempting to define the term "obese." Medical professionals are themselves torn over a definition, and adolescents seem to have little or no conception of how much they *should* weigh.

"Adolescents are always on a diet. They have a fetish about weighing less than they already weigh," says John DiTraglia, MD, a family practitioner who has treated numerous overweight adolescents in his Portsmouth practice.

It's not at all unusual, he says, for teenagers to come into his office and ask for a diet — whether they have any weight to lose or not.

Presently, there seems to be two schools of thought on whether or not a diet *should* be given in such cases.

According to H. Verdain Barnes, MD, an adolescent medicine specialist at Wright State University, you have to view the request from the adolescent's perspective. If it's *that* important to the individual, he says, then you have to work with them in that fashion.

"Help them devise a safe method of dieting, and follow them carefully as they lose," he suggests. Otherwise, the adolescent is apt to try to lose the weight on his or her own — often by following a fad diet which can do more harm (physically and emotionally) than good.

"Nutritional counseling is important for any and all of us," agrees Dr. Mitchell. While he doesn't condone passing out diets to teens who don't need to lose weight, he says the adolescent *could* be instructed in proper nutrition and given guidelines on what to eat without necessarily labeling it a "diet."

Others argue, however, that too much attention is already being given to body image and the need to be thin in this society.

"Some adolescents will always be on the heavy side," says Dr. DiTraglia. "It's a fact of life. Just as there are short people and tall people, dumb people and smart people, there are just some people who are never going to fit into a bikini."

Realistically, he says, most people who fall into this category are never going to lose more than ten percent of their body weight.

"To tell these teenagers that they can go on a diet and lose all this weight is telling them a lie," says Dr. DiTraglia. If they *do* manage to shed the pounds, they'll put them back on, he adds.

That's why he counsels overweight (but not obese) adolescents to accept their body weight — whatever it is.

Fredric Rothman, MD, an adolescent medicine specialist from Toledo, agrees that adolescence is the time to come to terms with body image — just as it is the time to recognize that everyone has certain genetic limitations.

"Every teenage boy wants to be at least six feet tall, but many of them never will be. I still have to deal with the fact that no matter how straight I stand, I will only be five feet, ten inches."

Acceptance of oneself is one thing, however — acceptance by one's peers is something else entirely. Still, peer approval is something no adolescent can be without.

"The telephone is the most important thing in an adolescent's life because it allows that all-important contact with the peer group," says Dr. Seligman.

The peer group functions like a safety net for the adolescent who is out there on that tightrope between dependence and independence, she explains, and Dr. Mitchell adds:

"The peer group provides protection in numbers, while allowing the adolescent to experiment with values and with superficial relationships."

As the adolescent matures, of course, his or her need for peer group approval diminishes, but during that time of self-discovery, adolescents need that validation, that approval and support from their friends to help them over the tightrope — even though at times it appears as though the peer group itself is responsible for much of the tension and stress today's adolescent experiences.

The peer group, however, is not the adolescent's only need.

According to Dr. Mitchell, many of the problems he sees in the Adolescent Clinic at Dayton's Dartmouth Hospital can be attributed to a lack of structure in the adolescent's life. Too often, he says, the adolescent is "turned loose" into an adult world — without support or guidance from parents — and expected to cope.

"Structure, provided by strong

"Too many parents allow their children to make decisions on their own, but this places tremendous stress on the adolescent."

parents and strong family ties are definitely needed by today's adolescents," says Dr. Mitchell. "Parents should avoid being a friend or a sibling to their adolescent. It is their responsibility to let the child know who is in charge."

He likens the role of the parent to a benevolent dictatorship. "They should use the word 'no' constructively, but they *should* use it — and they should help the adolescent to identify the growth and development process he or she is going through." With this background of understanding, he says, the child can better cope with the feelings and events, the chaos and turmoil which are occurring in his or her life.

But under *no* circumstances, stresses Dr. Mitchell, should the parents allow the youngsters to take charge.

"Too many parents allow their children to make decisions on their own, but this places tremendous stress on the adolescent. The teenager needs an adult authority figure nearby who is ready to take charge and make decisions," he comments. "It is an immense relief to the adolescent not to have to make all the decisions."

Even if the parent is not an ideal role model (or decision-maker), there are other authority figures to whom an adolescent can — and should — turn, says Dr. Mitchell. Teachers, clergy and organizations like Big Brother/Big Sister can provide the adolescent with the necessary adult guidance and support he or she needs.

Dr. Seligman agrees that the family itself is often at the root of many teenagers' problems.

"A dysfunctional family will only make an adolescent's problem worse," she says.

Parents who cannot communicate with each other or support each other are poor role models for children who learn coping, as well as other social interaction skills, from their parents and family. If the parents can't cope well with stress and tension, she asks, how can adolescents be expected to cope?

In addition, many teenagers get mired in the belief that it is *their* responsibility to make the dysfunctional family healthy.

"They will accept the blame for problems in the family because in that way they feel they have some control over the situation. They believe that if they can change, things will get better," says Dr. Seligman. But the reality is, of course, things seldom improve.

What should parents do, then, to avoid being at the "root of the problem?"

Besides saying "no" in a constructive manner, serving as good role models and providing some structure in their adolescent's life — "they should promote chaperoned activities during early adolescence, encourage individual support in later adolescence, and they need to be aware, themselves, of the growth changes the child is going through," says Dr. Mitchell.

He also urges parents to take an interest in the adolescent's peer group.

"Parents need to know who their child's friends are, and the friends need to know who the child's parents are," he says.

This doesn't mean a formal interview situation needs to be arranged, but a father, for example, should feel comfortable saying, "Hi, I'm Jack's dad," and be ready to list (and enforce) the house rules, if necessary.

Finally, there is the matter of the adolescent patient. Are there guidelines physicians (especially those in the primary care areas) need to observe when treating an adolescent with stress?

As far as the overweight adolescent is concerned, Dr. DiTraglia suggests that physicians be patient with the teenager who is trying to lose weight. Concentrate more on counseling the child than on prescribing diets, he says.

"Some doctors play into this diet belief. They prescribe diets, then they don't believe the child when he or she fails to lose weight. They think the child is cheating. That kind of attitude is demeaning and frustrating for the child. When the child fails to lose, it's just one more notch to add to that lack of self-confidence."

In *any* case, says Dr. Seligman, physicians need to take teenagers seriously.

"There is always the danger that a physician may not take an adolescent's needs seriously enough. Yet to treat an adolescent effectively, you have to hear what the teen is saying, and try to understand why he or she feels that way" — whether the problem be an extra 10 pounds, a pimple, or uncommunicative parents.

Yet, a word of caution.

"Although you have to take them seriously — you also have to take them with a grain of salt at the same time," she says. "Recognize that what is so important to them today may not even be an issue with them tomorrow — but don't put them down for it."

"There are so many developmental rungs on the ladder that what might be perceived as a mental illness might actually be normal."

Dr. Seligman advises physicians in primary care areas to arrange for consults with mental health professionals when they're in doubt as to how best to proceed with an overwrought teen. "They can help give the primary care physician some direction in treating the adolescent," she says.

Dr. Mitchell agrees.

"Although different types of mental health problems can occur at this age level, it is best to refer the adolescent to a child or adolescent psychiatrist rather than to attempt a diagnosis yourself," he says. "There are so many developmental rungs on the ladder that what *might* be perceived as a mental illness might actually be normal."

It is Dr. Seligman, however, who perhaps sums up adolescence — and how to treat it — the best.

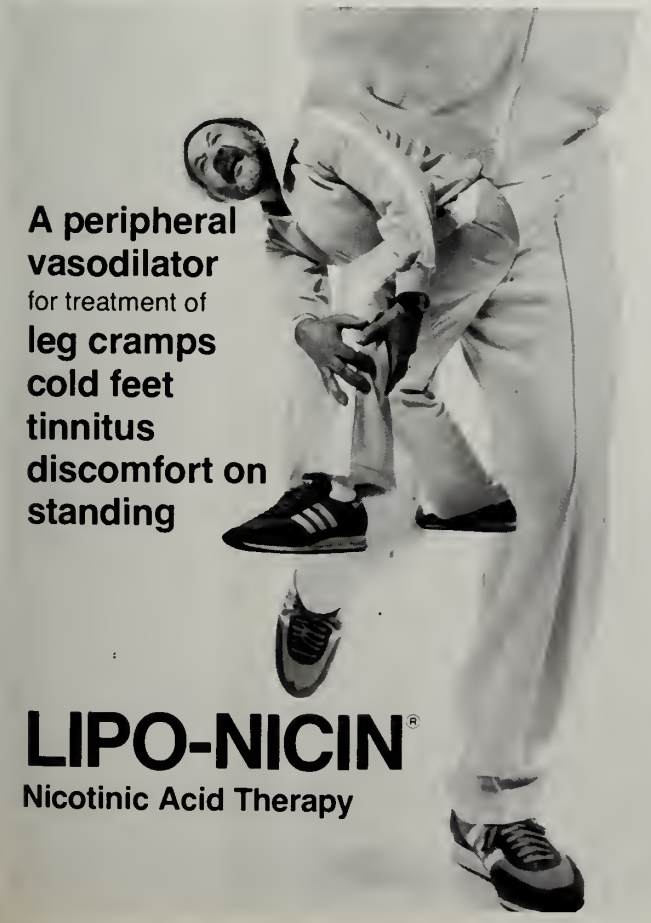
"It is a period of such rapid change. It reminds me of that old saying, 'I'm not clumsy, it's just that my head is too far from my feet.'

"But it's also an exciting time. Adolescents are learning, thinking differently than they've ever done before — they're projecting thought into the future for the first time, and they're so full of life. No one feels as intensely as they do," she says.

Yet, at the same time, adolescents are still malleable, moldable. Physicians, parents, authority figures can still intervene effectively when and if it's necessary because nothing is fixed yet — nothing is carved in stone. As Dr. Seligman notes:

"It is easier to change them now — at this stage — than it is to try to change them as adults." OSMA

Karen S. Edwards is the Executive Editor of **Ohio Medicine.**



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Teaching Teens to Trust

By Susan Porter



Adolescence has always been a difficult period in human development; a time of mood swings, growth spurts and, frequently, utter confusion. Yet due to relaxed social standards, fast-paced lifestyles and the enormous variety of choices society now offers individuals of all ages, today's teens live in a pressure-cooker environment, and the statistics seem to indicate that the lid is about to blow.

Thus, the time has come to "take this bull by the horns," in the words of James H. Sammons, MD, Executive Vice President of the American Medical Association, who last year called for a special AMA White Paper on Adolescent Health. Dr. Sammons discussed the results of that White Paper in a special live teleconference via the Hospital Satellite Network on January 28, asking physicians across the country to "declare an all-out war" on the health problems facing today's teens. He was joined in the 90-minute program by a panel of experts from around the country who agreed that these problems have reached a crisis stage — and it is up to the medical profession to help solve that crisis.

One of the biggest ways doctors can contribute is by helping adolescents to trust the medical care system, said the director of an adolescent health clinic in Chicago. Too often, she said, teens are treated as either "big children," or "small adults" — leaving them in a medical no man's land. "We want teens to feel that physicians, nurses and social workers are their first line

of defense," where health care problems are concerned, she said.

The need for quality, accessible and affordable health care is critical in the teenage population because the majority of adolescents do not receive the care they need. Dr. Sammons suggested the formation of community-based clinics for teens, where hospitals could donate space and physicians could donate time to ensure teens have access to confidential and convenient care. "We must be both available and affordable," said John J. Hutchings, MD, of the U.S. Department of Health and Human Services during the teleconference.

But first, said Dr. Sammons, physicians "need to educate ourselves as to what adolescents' problems are and we need to start listening to what adolescents have to say." A major thrust of the AMA's new Program on Adolescent Health will be educating physician members about adolescent health care and giving advice and information on how they can be more active in their own community. Future issues of *AM News* and all of the AMA's specialty journals will be focusing on adolescent health in the coming months, Dr. Sammons reported.

The program will also include the creation of an information center at the AMA for the collection and dissemination of information, Dr. Sammons explained. Later, the effort will be "expanded to include a lot of other people," he adds, such as parents, teachers and others working with youth in the community.

Adolescence . . . the best of times . . . the worst of times

The American Medical Association has designed a new adolescent health program to try to make the transition into the teenage years as smooth as possible. The AMA will call together individuals from the health and education professions, social services, government agencies, and professional and community groups to analyze and to try to alleviate "the worst of times" in the lives of American youths.

Some of the major areas the AMA adolescent health program will focus on include:

- **Substance abuse.** Two-thirds of American youth use an illicit drug before they're out of high school. One in five smokes cigarettes daily. One in 16 drinks daily.
- **Sexuality/pregnancy.** Forty-six percent of all births to unmarried women are to teenagers — so are one-third of abortions. Two-thirds of sexually active adolescent females do not use contraceptives.
- **Victimization.** Twenty-four percent of all fatalities and 41% of serious injuries in reported cases of physical abuse involve young people age 12-17. Half of all rape victims are under age 18. An estimated 900,000 teenage girls and boys work as prostitutes.
- **Psychological/suicide.** Each year some 5,000 young people under 19 commit suicide; 50,000 attempt it. Up to 10% of girls in their teens have an eating disorder.
- **Violence/trauma.** Adolescents are responsible for one-third of all violent crimes.

"We've always regarded our young people as our greatest resource, the key to our nation's future. But many of them will never grow to adulthood, their lives cut short by suicide, drugs, tobacco and alcohol abuse, violent crime, and unfortunate but preventable accidents," said John J. Courey, MD, AMA president, in *American Medical News*. "When you think of it, there is probably no professional group that is better qualified than physicians to sponsor a call for a truly comprehensive approach to understanding — and meeting — the health needs of our young people." — *Deborah Athy*

Physicians are also being asked to become more personally involved in dealing with the adolescent patient. "As physicians, we need to be more sensitive to the individual needs of adolescents," said Edward Langston, MD, a family practitioner from Indiana who appeared on the telecast. "We can also assume role models and help teach teenagers responsibility."

Those who don't feel comfortable dealing with teens, Dr. Sammons added, should not be afraid to "refer them to someone who can and will help."

And finally, doctors need to become more involved in research, "to test, to experiment, to develop positive relationships with teens and parents," concluded the AMA teleconference program moderator. "To do less puts an entire generation — and our future — at risk." **OSMA**

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The AMA Interim Report

By Oscar W. Clarke, MD and John E. Albers, MD

This report covers some of the important issues voted on by the Ohio Delegation at the 1986 Interim Business Meeting of the American Medical Association House of Delegates in Las Vegas, Nevada, December 7-10, 1986.

There were 94 reports and 142 resolutions considered by the House of Delegates.

Smoking and the Entertainment Industry

The American Medical Association adopted the following amended resolution submitted by the Ohio Delegation:

"RESOLVED, That the American Medical Association encourage the entertainment industry to continue to de-emphasize the role of smoking on television and in the movies."

Resident and Student Representation on the Council on Ethical and Judicial Affairs

The American Medical Association adopted an amended Board of Trustees Report that endorses the addition of a resident and a medical student to the Council on Ethical and Judicial Affairs. The report recommends that the medical student and resident physician members of the Council be nominated and elected in the same manner as the other seven members of the Council; that the term of the medical student member of the Council be two years and the tenure be no more than two terms, contingent on the medical student's continued enrollment in an approved medical school; that the term of the resident physician member of the Council be three years and the tenure be no more than two terms, contingent on the resident's continuation in an approved training program; and that the resident physician member of the Council have voting privileges, that the voting privileges of the medical student member of the Council be determined each term by the Council, but that neither the medical student member nor the resident member of the Council vote on matters involving the Council's judicial authority.

Abortion

The American Medical Association House of Delegates reaffirmed the following policy statement on abortion in lieu of a resolution on that subject:

"Abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state.

No physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice."

Billing Procedures for Emergency Care

The American Medical Association House of Delegates adopted a Council on Medical Service report in lieu of several resolutions. The report suggests that physicians providing emergency care assure that the services that they provide are accurately and completely described and coded on claim forms, that the AMA adopt a

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policy statement on reimbursement for such services, and that state and local emergency medicine groups be encouraged to work with third-party payers to implement appropriate description, coding and payment practices.

Capitation as a Payment Mechanism for Medicare

The American Medical Association House of Delegates referred the following resolution to the Board of Trustees for a report back to the House of Delegates:

"RESOLVED, That the American Medical Association urge the United States Congress, the Health Care Financing Administration and the President to immediately halt the expansion of federal capitation programs for Medicare, Medicaid and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) until the problems that have surfaced in Florida and elsewhere around the country can be thoroughly evaluated."

Inequities of DRG Payments to Hospitals

The American Medical Association House of Delegates filed a Board of Trustees report that presents a brief review of the issue of potential inequitable DRG payments to rural hospitals, stating that current AMA policy on this topic remains appropriate, and reporting that the Council on Medical Service will include this issue in its current study of rural health care to be completed at the 1987 Annual Meeting.

In addition, the House of Delegates referred the following two resolutions to the Board of Trustees for a report back to the House of Delegates:

Change in Criteria for Rural Referral Center Designation

RESOLVED, That the American Medical Association study the issue of changes in the criteria for designation and retention of rural referral centers by the Health Care Financing Administration; and be it further

RESOLVED, That the AMA oppose changes to rural referral center designations which would adversely affect the scope of quality of medical services offered by rural referral centers."

Medicare and Medicaid Regulations Impacting upon Physicians and Hospitals in Rural and Isolated Areas

"RESOLVED, That the AMA take the lead in bringing about changes in laws, regulations and requirements of the Medicare and Medicaid programs which will reflect, more realistically, upon the capacity of hospitals and physicians in rural and isolated areas to provide medical and health care services to the elderly, the poor and residents of those areas; and be it further

RESOLVED, That the Board of Trustees review those laws, regulations and requirements which are having an adverse impact on the delivery of care to residents of rural and isolated areas for the development and implementation of a program of action; and be it further

RESOLVED, That the Board of Trustees consult with the American Hospital Association, American Association of Retired Persons, National Farm Bureau and other national organizations whose institutions and members also are adversely affected, and invite them to join in legislative initiatives which are designed to ameliorate this growing problem; and be it further

RESOLVED, That the Board of Trustees initiate these activities at the earliest possible time in recognition of the urgent needs of small, rural hospitals, their medical staffs and the people they serve."

Report of the Special Task Force on Professional Liability and Insurance and the Advisory Panel on Professional Liability

The American Medical Association House of Delegates adopted a Board of Trustees report in lieu of several resolutions. The report provides an overview of significant events in 1986 concerning professional liability, a review of AMA activities during the last year, and a description of the plan for the coming year of AMA's Special Task Force on Professional Liability and Insurance and the Advisory Panel on Professional Liability. The report notes that the Association will continue to be the leading advocate on the national scene for a more rational professional liability system. Operation of the Clearinghouse on Professional Liability will continue, as will the Association's efforts to assist state medical societies in their legislative programs, and the Association will continue to work for federal Congressional action on this issue. The report also notes that the AMA/National Medical Specialty Society Coordination Project will intensify its work in 1987.

In addition, the AMA House of Delegates referred the following resolution on the same subject to the Board of Trustees for action:

"RESOLVED, That it is the policy of the American Medical Association to incorporate a statute of limitations for minors

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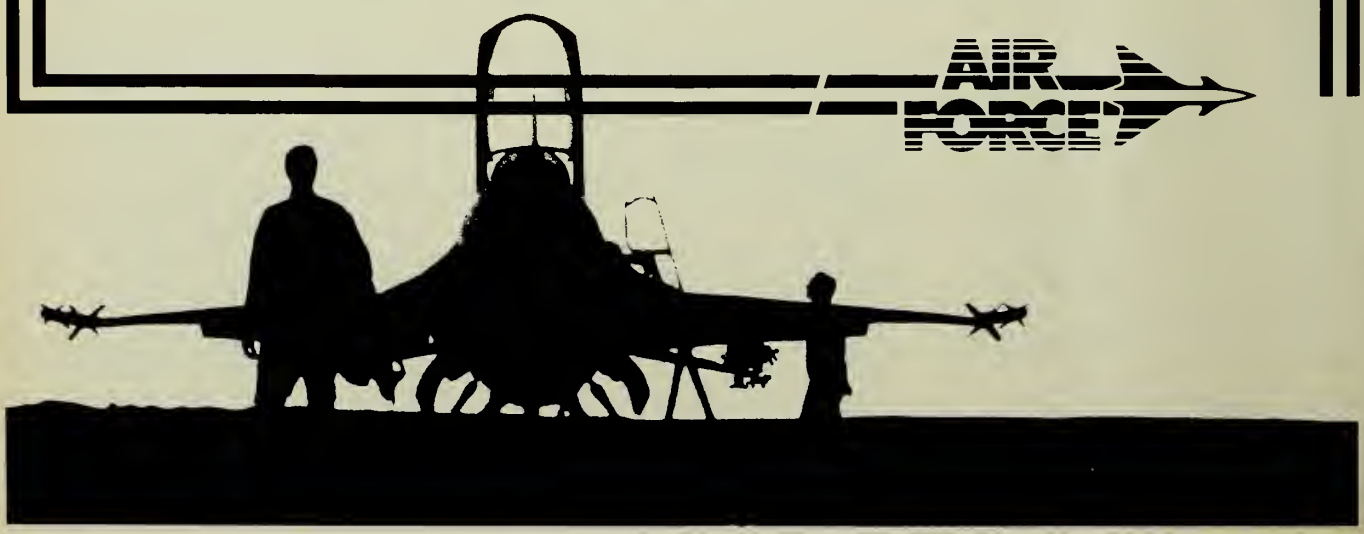
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provision in the language of any professional liability tort reform legislation it causes to be introduced; and be it further

RESOLVED, That the AMA urge each state society to do likewise for any state professional liability tort reform legislation it causes to be introduced; and be it further

RESOLVED, That in no instance will the language pertaining to statute of limitations for minors be introduced in such form as to pre-empt presently existing state statutes of limitations which the state society believes to be more favorable than the language proposed in the AMA's professional liability tort reform legislation."

The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509)

The American Medical Association House of Delegates adopted a Board of Trustees report regarding the Omnibus Budget Reconciliation Act (OBRA), explaining that it makes substantive changes to the Medicare program. The report notes that the Association has undertaken a number of activities to provide information to the House of Delegates and the membership with information on this law, and that the Association will continue to meet with HCFA administrators as the law undergoes implementation. The report further notes that the AMA Office of the General Counsel is monitoring developments and will review all available legal options.

In addition, the AMA House of Delegates adopted the following resolution:

"RESOLVED, That the American Medical Association take whatever steps are necessary to obtain injunctive relief to enjoin implementation of the Medicare Part B fee provisions of Omnibus Budget Reconciliation Act (OBRA) of 1986."

PRO Sanctions

The American Medical Association House of Delegates adopted a Board of Trustees report in response to an earlier resolution that called for the AMA to seek amendment to the Social Security Act to allow physicians the right to judicial review before any PRO sanctions can be imposed against them. The Board reported that such an amendment has been developed and immediate action will be taken to seek necessary modification.

Blood Alcohol Level

The American Medical Association House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association reiterate existing policy supporting 0.05 or higher blood alcohol content as per se illegal for driving and urge incorporation of that position in all state drunk-driving laws."

Tax Deduction Status on Educational Loans

The American Medical Association House of Delegates adopted the following amended resolution:

"RESOLVED, That the American Medical Association monitor the impact of the elimination of the tax deductible status of interest paid on student education loans; and be it further

RESOLVED, That the AMA support the principle that interest on student educational loans should remain tax deductible; and be it further

RESOLVED, That the American Medical Association seek a legislative remedy to the portion of the 1986 Tax Reform Act that eliminated the deduction of the interest on educational loans."

National Computerized Graduate Medical Education Service

The American Medical Association House of Delegates referred a Council on Medical Education Report to the Board of Trustees for action. The Council report recommends that, contingent upon availability of funds, a computerized service be established by the AMA to provide printed detailed information on accredited residency and fellowship programs.

Re-Evaluation of Residency Selection Process

The American Medical Association House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association continue to cooperate with the Association of American Medical Colleges in its evaluation of the residency selection process with emphasis on 1) the reduction of pressures that induce premature specialty decisions within the undergraduate medical curriculum, and 2) efforts to encourage all residency programs to offer their positions in the National Residency Matching Program and to adhere to the guidelines of that program."

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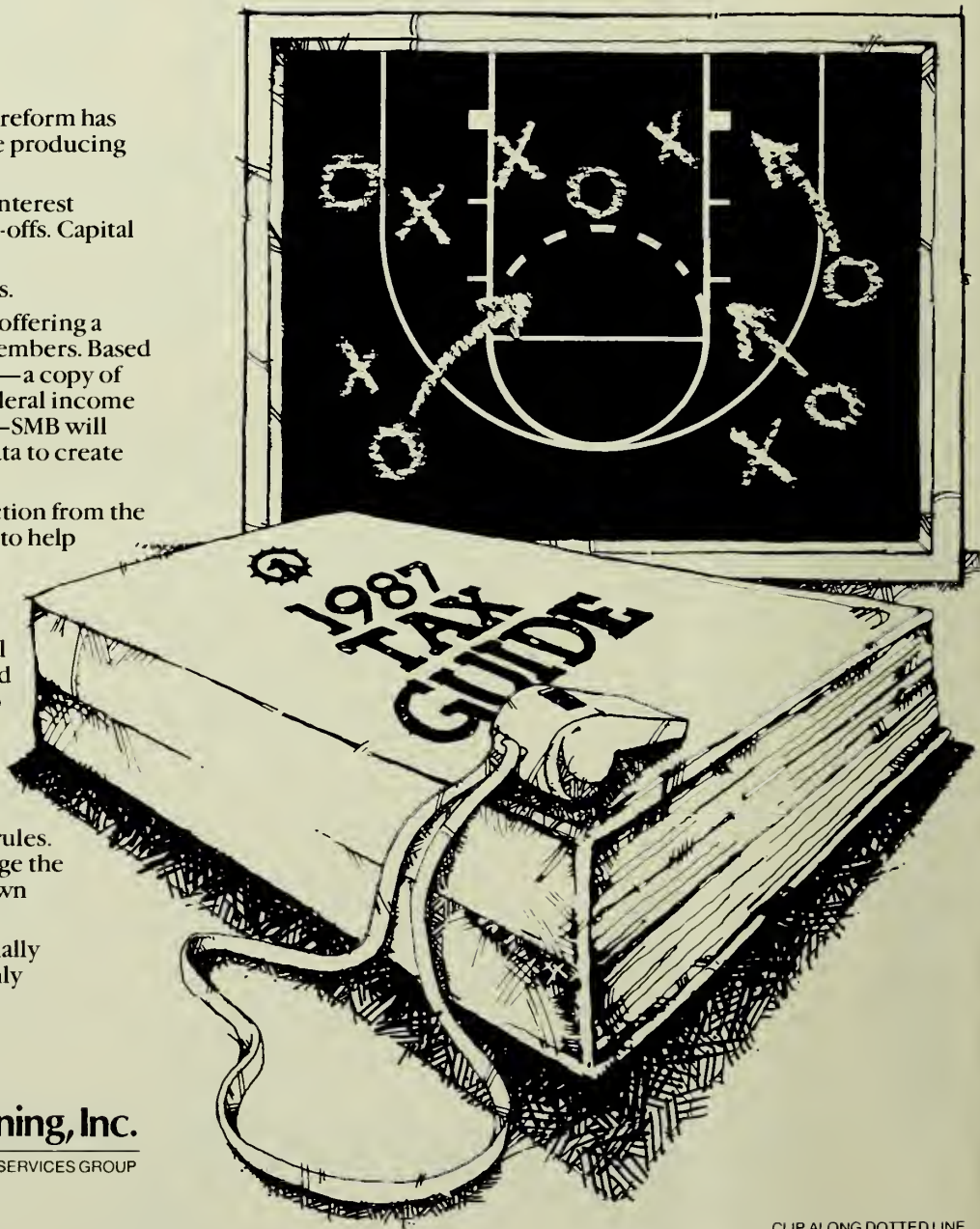
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Bylaws Approval Time Limit

The American Medical Association House of Delegates adopted the following substitute resolution:

"RESOLVED, That the AMA asks its Commissioners to the JCAH to propose a standard in the "Accreditation Manual for Hospitals" requiring that initial medical staff bylaws and subsequent amendments be approved or disapproved by the hospital governing body within a reasonable period of time specified in the medical staff bylaws; if the governing body fails to act within the time specified, the proposed changes would be deemed adopted."

Hospital Decisions to Grant Exclusive Contracts

The American Medical Association House of Delegates adopted a Board of Trustees Report that reviews several options for the Association to pursue to assure that due process, in any attempt to abridge hospital privileges, is accorded to physicians when exclusive contracts are granted by the hospital governing body. The five methods considered, which have been reviewed by the Office of the General Counsel, are as follows:

1. Preparation of model bylaw provision which, if adopted, would impose due process requirements before the granting of an exclusive contract;
2. Drafting of model state legislation involving due process and exclusive contracts;
3. Advising of physicians on the possibility of requiring due process by contract;
4. Filing of a brief *amicus curiae* in an appropriate case in which a physician's privileges have been abridged by virtue of an exclusive contract without due process;
5. Advocacy of a JCAH standard that would require full due process before a physician's privileges are abridged by the granting of an exclusive contract.

Medical Staff Comment on JCAH "Field Review of Proposed Standards"

The American Medical Association House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association Board of Trustees direct its commissioners to the Joint Commission on Accreditation of Hospitals work to assure that all "Field Review of Proposed Standards" that are sent to hospitals be sent simultaneously to the medical staff of said hospital with their comments to be returned directly to the Joint Commission for their consideration.

AMA Physician Masterfile Coding

The American Medical Association House of Delegates adopted a Board of Trustees report in lieu of an earlier resolution on the same subject. The report recommends that the AMA continue to include information on self-designated practice specialties as well as board certification and residency training history in the AMA Physician Masterfile and that the complete term "self-designated practice specialties" be used to refer to Masterfile codes related to physicians' current practice activities.

Characteristics of AMA Delegates

The American Medical Association House of Delegates referred a report of the Council on Long Range Planning and Development to the Board of Trustees that recommends that AMA Delegates and Alternate Delegates be elected or selected by AMA members only and that the membership of the AMA House of Delegates be limited to AMA dues-paying members. The report recommends voter membership because: 1) It would strengthen the relationship between AMA members and Delegates; 2) Voting for Delegates is an important method of identifying members' preferences; 3) Non-members seeking a voice in organized medicine may be encouraged to join the AMA; and 4) Physicians might be more likely to support the AMA if their votes count more.

Establishment of a Special Section for Foreign Medical Graduates

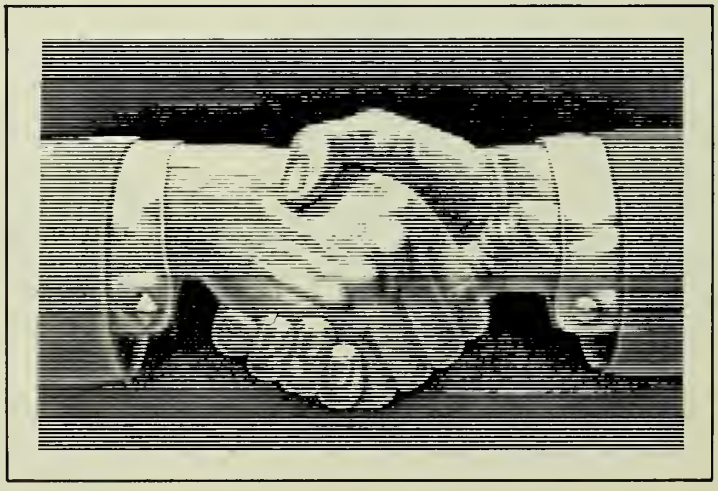
The American Medical Association House of Delegates referred the following resolution to the Board of Trustees:

"RESOLVED, That the American Medical Association form a section for graduates of foreign medical schools similar to the Medical Student, Resident Physicians, Hospital Medical Staff and Young Physicians Sections; and be it further

RESOLVED, That the Board of Trustees be requested to submit to the House of Delegates at its June 1987 Annual Meeting the necessary criteria for establishing a Section for Graduates of Foreign Medical Schools."

The Board has been directed to develop a plan of action intended to increase the active involvement

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and membership of foreign medical graduates in the AMA, with the formation of a section as an option.

Tax Deductibility of Professional Association Dues

The American Medical Association House of Delegates referred the following resolution to the Board of Trustees:

"RESOLVED, That the American Medical Association seek to have legislation introduced as soon as feasible that would make professional association dues a fully deductible expense for all physicians, not merely a portion of them."

Peer Review Organization (PRO) Program

The American Medical Association House of Delegates adopted a Council on Medical Service report which responds to two earlier resolutions concerning the PRO contract renewal process and relating to review of HCFA Rules and Regulations concerning PROs. The report discusses current directions in the PRO program and recent legislative mandates having an impact on PRO contained in COBRA and OBRA. The report also discusses issues raised by the operation of the SuperPRO, the imposition of sanctions by PROs, and the authority for PROs to deny payment on the basis of quality. In addition, the report makes the following recommendations:

1. That the AMA develop draft federal legislation providing that a PRO shall not notify a beneficiary of a PRO determination that the quality of medical services provided does not meet professionally recognized standards of health care until the cited practitioner has obtained a timely PRO reconsideration of the determination and exhausted rights to judicial review of any adverse reconsideration decision.
2. That the AMA continue to call for HCFA policy transmittals to be effective only upon or after their date of issuance and that they *not* be retroactively enforced as has often been the case in the past.
3. That PROs, as well as the SuperPRO, more actively solicit input from organized medicine regarding the development of criteria sets and generic screens which are used in the PRO review process. As a part of this recommendation, the Council urges the physician community, in particular specialty medical societies, to work with PROs in improving their review criteria.

In addition, the AMA House of Delegates adopted the following resolution:

"RESOLVED, That the American Medical Association immediately seek modification of Sections 2003.2 entitled "Content of the Notice," as found in the Medicare Peer Review Organizational Manual, to ensure that all appeal mechanisms available to the physician be exhausted before the beneficiary is sent a denial letter and that the language used in the letter sent by the peer review organization (PRO) be properly worded to ensure that the patient/physician relationship is not jeopardized and that the physician is provided with the fundamental principles of fairness and due process."

PRO Sanctions

The American Medical Association House of Delegates referred the following substitute resolution to the Board of Trustees for action:

"RESOLVED, That the American Medical Association in its communications with the Department of Health and Human Services seek greater PRO discretion in the determination and handling of sanction recommendations, and be it further

RESOLVED, That the AMA undertake legal action, as appropriate, to assure that physicians are accorded due process appeal rights in the course of PRO sanction and denial processes; and be it further

RESOLVED, That reconsiderations and appeals of PRO actions be heard before panels of physicians in active practice."

PRO Legislation Repeal

The American Medical Association House of Delegates referred the following resolution to the Board of Trustees for action:

"RESOLVED, That the American Medical Association immediately seek legislation to repeal the Peer Review Organization (PRO) legislation."

PRO Programs

The American Medical Association House of Delegates referred the following resolution to the Board of Trustees for action:

"RESOLVED, That the American Medical Association, in conjunction with the American Hospital Association, work with appropriate federal officials in an attempt to resolve quality problems with the Peer Review Organizations (PROs); and be it further

RESOLVED, That the AMA work with the Health Care

Financing Administration in revising the regulations to require a physician employed by the PRO to review all denials; and be it further

RESOLVED, That the AMA urge revision of the Health Care Financing Administration regulations to require that reconsideration of denials be done by subspecialty physician peers at the reconsideration level."

Medical Staff Involvement in PRO Quality Determination

The American Medical Association House of Delegates referred the following resolution to the Board of Trustees for action:

"RESOLVED, That the American Medical Association adopt as policy and transmit to the Health Care Financing Administration that PRO rules and regulations include that medical staffs shall be informed when a quality care issue is felt to exist; and be it further

RESOLVED, That the AMA adopt as policy that medical staff be allowed to comment upon the perceived quality care issue in the appropriate fashion — with such participation being protected under appropriate federal and state prohibitions about discoverability of such information."

Impact of Federally Mandated Peer Review on Graduate Medical Education

The American Medical Association House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association study the impact of current peer review policies mandated by the federal government on graduate medical education and on physicians who volunteer their time to train resident physicians."

Establishing Complicated Readmissions and Earlier Original Admissions as a Single Admissions Payment and Review Purposes Under the DRG System

The American Medical Association House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association seek revision in current PRO regulations which require automatic denial by a PRO of second admission to the same hospital; and be it further

RESOLVED, That the review of the second admission be conducted on a case-by-case basis, taking into consideration the degree of complication and nature of the readmission."

PRO Guidelines

The American Medical Association adopted the following substitute resolution:

"RESOLVED, That the American Medical Association enlist the aid of Medicare patients by encouraging them to voice any valid concerns with the PRO program to their elected federal officials, and that individual physicians should encourage and facilitate such valid patient complaints against the PRO program, and forward such complaints to the AMA."

DRGs for Physician Services to Hospital Inpatients Under Medicare

The American Medical Association House of Delegates adopted a Board of Trustees report that outlines a recent proposal by the Office of Management and Budget (OMB) which calls for the combining of reimbursement for hospital and physician inpatient services into a single DRG payment. The report reiterates current AMA policy which opposes the extension of the DRG system to physician services. The report emphasizes that the Board will take appropriate actions to seek to delete this OMB proposal from incorporation in the Administration's budget proposals to Congress.

The AMA House of Delegates also adopted the following amended resolution:

"RESOLVED, That, since 48% of the 1,000 physicians surveyed by the AMA in June 1986 stated that they felt "unduly pressured" to discharge Medicare patients early, the American Medical Association reaffirm its strong opposition to inclusion of physicians in any global DRG system, and be it further

RESOLVED, That the adequate and appropriate resources of the Federation of American medicine be mobilized forthwith to impress upon the President and the Congress the danger this proposal represents and the threat it poses to the American people."

Patient's Choice of Physician

The American Medical Association House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association reaffirm its existing policy emphasizing patients' freedom of choice of physicians or of health care delivery systems; and be it further

RESOLVED, That education of

the public on these multiple delivery systems be an integral part of the AMA's public awareness program."

Funding for State Medical Boards

The American Medical Association House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association urge state medical associations to recommend to their respective state legislatures that all fees and charges collected by the state licensing/disciplinary board(s), or on its behalf, should be specifically designated for use of the board(s) in fulfilling its duties under the state's medical practice act; and be it further

RESOLVED, That the state licensing/disciplinary board(s) should be authorized to set fees at levels adequate to support the board(s) effective fulfillment of its duties mandated by the state's medical practice act."

Quality of Medical Care in Major Surgical Procedures

The American Medical Association House of Delegates adopted the following amended resolution:

"RESOLVED, That the American Medical Association recognize that demands on the attending physician by third party carriers to admit patients to the hospital on the same day of surgery may compromise the quality of medical care in cases where major surgical procedures are scheduled; and be it further

RESOLVED, That the AMA identify this as one of its concerns when discussing quality of care with third party carriers."

Mandated Outpatient Surgery

The American Medical Association House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association communicate to third party payers that the choice of operating environment must remain a matter of professional judgment of the patient's physician, and request that third party payers reevaluate their positions on this issue."

Handguns as a Public Health Problem

The American Medical Association House of Delegates adopted the following substitute resolution:

"RESOLVED, That the AMA review the effectiveness of programs designed to reduce the deaths and injuries caused by handguns and report its findings at the 1987 Interim Meeting; and be it further

RESOLVED, That the AMA support and promote educational programs by nationally funded research organizations which have been found to demonstrate a reduction in the deaths and injuries caused by handguns."

Removal of Mandatory Assignment for Office-Based Laboratory Procedures

The American Medical Association House of Delegates adopted the following resolution:

"RESOLVED, That the American Medical Association appeal to the Congress to repeal the Medicare requirement that physicians accept assignment for laboratory procedures performed in the office; and be it further

RESOLVED, That the AMA Board of Trustees ascertain and initiate the most effective approach to repeal the Medicare requirement that physicians accept assignment for laboratory procedures performed in the office."

Multistate Collaborative Database of the Impaired Physician: A Pilot Study

The American Medical Association House of Delegates adopted a Board of Trustees report which responds to the need for a standardized data collection system on impaired physicians. The goal of the Board is to develop a multistate collaborative database that can be used to provide more accurate assessment of the scope of physician impairment, to define impairment more clearly and establish categorical priorities, to develop and implement research and control programs to reduce the incidence and prevalence of impairment, and to evaluate these programs on an ongoing basis.

There are many excellent reports presented to the House of Delegates at each meeting covering a wide range of subjects that are of interest to physicians. These reports, prepared by the AMA Board of Trustees, councils, committees and staff, contain a wealth of information.

A listing, by title, of some of the reports follow. If you would like a copy of these reports, please contact the OSMA office.

1. Report on Missing and Exploited Children
2. Suicide Prevention Program for Medical Students and Physicians
3. AIDS Status Report
4. Veterans Care
5. Automatic External Cardiac Defibrillators for Emergency

Use in Transoceanic Air and Water Transportation
6. National Disaster Medical System
7. Survey of Medical Society Initiatives on Health Care for the Elderly
8. A National Study of Resource-Based Relative Value Scales for Physicians' Services: Status Report
9. ICD-9CM Update
10. AMA Membership Among Large Medical Groups
11. Health Policy Agenda for the American People: Current Status and Plans
12. Home Health Care
13. AIDS Status Report: Update on Recent Developments in HIV Antivirals
14. The Future of Medicine: A Scenario Analysis
15. Specialty Society Representation in the House of Delegates — Interim Report
16. Essentials for Approval of Examining Boards in Medical Specialties
17. Health Insurance Incentives for Tobacco Non-Users
18. Drug Abuse in Athletes: Anabolic Steroids and Human Growth Hormone
19. The Heimlich Maneuver
20. Discrimination Against AIDS Patients
21. Warning Labels on Over-the-Counter Iron Preparations and Dietary Supplements

Oscar W. Clarke, MD, is Chairman of the Ohio Delegation to the AMA. John E. Albers, MD, is co-chairman, and President of the OSMA.

Please send me the following AMA report(s) listed in the Summary of Actions Report of the 1986 AMA Interim Meeting:

Report Number(s)_____

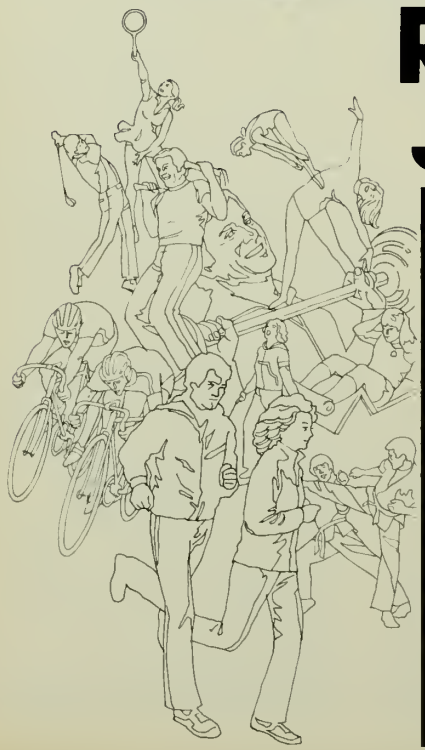
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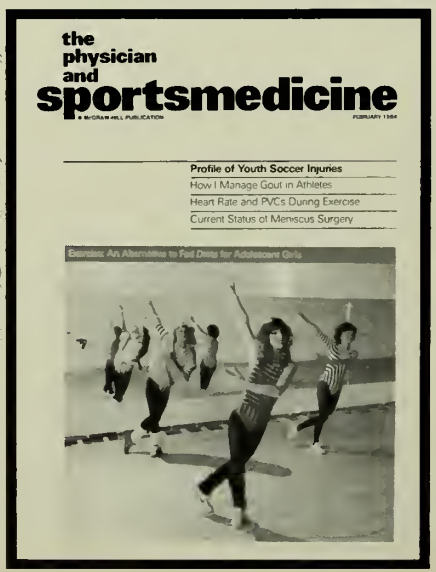
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Proposed Changes to OSMA Constitution and Bylaws

Editor's Note:
The following three resolutions have been submitted for consideration at the 1987 OSMA Annual Meeting. Since these resolutions propose to change the OSMA Constitution and Bylaws, they must be published in the OSMA Journal 60 days before the meeting, as is required by Article II of the constitution and Chapter 15 of the bylaws.

Proposed Council Resolution A — Spouse Active Membership

WHEREAS, An increasing number of couples in which both spouses are physicians are entering medical practice; and

WHEREAS, It is estimated in Ohio alone there are 300-400 physician couples; and

WHEREAS, With many physician couples, only one spouse is an active member of organized medicine; therefore be it

RESOLVED, That the OSMA Council, in an effort to recruit more physician/physician couples, each with separate membership, recommends that a new category of membership be created to allow for dual membership by spouses with a reduced dues structure for the couple; and be it further

RESOLVED, That the Constitution and Bylaws of the OSMA be amended as follows:

CONSTITUTION

ARTICLE III — Section 1

1. Active members/spouse active members (including retired active members)

BYLAWS

Chapter 1.
Section 2. Classification of Membership.

(a) Active members/spouse active members. Active members of this Association shall comprise all the active members and spouse active members in good standing of the several component societies. Active members and spouse active members shall have the right to vote and hold office.

Chapter 2.
Section 1. Determination of Dues. The annual dues and assessments of Active Members and Associate Members of this Association shall be determined by the House of Delegates and shall be levied per capita on such members. A member who is the spouse of an active member is eligible for a reduction from the per capita dues and assessments determined by the House of Delegates. The Council of this Association shall have the authority to promulgate the amount of dues and assessments for an active member's spouse. They shall be payable before January 1, of the calendar year for which such dues are levied. The dues and assessments shall be collected by the designated officer of each component society and shall be forwarded to the headquarters of this Association, together with such data as shall be required by this Association for its own record of such society's officers and membership.

Proposed Council Resolution B — Multi-County Membership

WHEREAS, Numerous members of the OSMA practice medicine at more than one location; and

WHEREAS, Many physicians have practices that span more than one county; and

WHEREAS, Physicians with extended practices wish to maintain professional ties and active involvement in more than one county medical society; therefore be it

RESOLVED, That the OSMA Council recommend that the association amend its bylaws to create a category of "multi-county members" to allow for full dues paying members of two or more societies to be active participants in each of those county medical societies; and be it further

RESOLVED, That the OSMA Constitution and Bylaws be amended as follows:

CONSTITUTION

ARTICLE II — Section 3. ~~Membership in Adjoining Society.~~ **INSUFFICIENT NUMBERS OF PHYSICIANS FOR FORMATION OF COMPONENT COUNTY SOCIETY.** If there should be an insufficient number of physicians in any county to form themselves into a component county society, such physicians may become members of the component society of an adjoining county, if they are otherwise eligible under the Constitution and Bylaws of such adjoining component society.

ARTICLE III — COMPOSITION OF THE ASSOCIATION

Section 1. Classes of Members. The Association shall consist of the following classes of members:

1. Active Members (including retired active members)
2. **MULTI-COUNTY MEMBERS**
3. Associate Members
4. Members in Training
5. Non-resident Members
6. Honorary Members
7. Military Members
8. Affiliate Members
9. Student Members
10. Corporate Members

ARTICLE IV — HOUSE OF DELEGATES

FIRST PARAGRAPH — NO CHANGE

SECOND PARAGRAPH SHOULD READ AS FOLLOWS:

For purposes of representation in the House of Delegates, **MULTI-COUNTY MEMBERS**

SHALL BE COUNTED AS MEMBERS FROM THEIR PRIMARY COUNTY OF MEMBERSHIP; student members shall not be counted at the individual district level, but shall constitute a separate section which shall be treated and seated as if it were an additional district in which the student members of each medical school elect their own delegate; the Hospital Medical Staff Section shall have one representative to the House of Delegates commencing with the Annual Meeting in 1985, said delegate to be selected in accordance with Bylaws of the Medical Staff Section to be approved by Council; (4) delegates and alternate delegates to the American Medical Association from Ohio, Past Presidents and Past Councilors of this Association each of whom shall be an ex-officio member without right to vote unless such delegate, alternate delegate or past president be a duly elected delegate from a component society or a duly elected officer of this Association.

BYLAWS

CHAPTER 1
MEMBERSHIP

Section 1 — no change

Section 2 — Classification of Membership

(b) MULTI-COUNTY MEMBERS. MULTI-COUNTY MEMBERS OF THIS ASSOCIATION SHALL COMPRISE ALL THOSE MEMBERS IN GOOD STANDING WHO ARE MEMBERS OF TWO OR MORE ADJACENT COMPONENT SOCIETIES. A MULTI-COUNTY MEMBER SHALL DECLARE PRIMARY MEMBERSHIP IN ONE COMPONENT SOCIETY. MULTI-COUNTY MEMBERS IN GOOD STANDING OF THIS ASSOCIATION SHALL HAVE THE RIGHT TO VOTE AND HOLD OFFICE, EXCEPT THAT SUCH MEMBER SHALL BE ELIGIBLE FOR ELECTION AS COUNCILOR, DELEGATE OR ALTERNATE DELEGATE TO THE HOUSE OF DELEGATES ONLY FROM THAT COMPONENT SOCIETY DESIGNATED AS THE SOCIETY OF PRIMARY MEMBERSHIP.

CHAPTER 4
THE HOUSE OF DELEGATES

Section 2 — Ratio of Representation. Each component society shall be entitled to one delegate in the House of Delegates for each one hundred (100) Active Members, Associate Members, and Members in Training, or fraction thereof, in good standing in this Association; provided, however, THAT ONLY THE COMPONENT SOCIETY IN WHICH A PHYSICIAN HOLDS PRIMARY MEMBERSHIP SHALL LIST A MULTI-COUNTY MEMBER ON THE MEMBERSHIP ROSTER; PROVIDED, FURTHER, that each component society shall be entitled to at least one delegate and one alternate delegate. The names of such delegates and alternate delegates shall be submitted to the headquarters of this Association at least thirty (30) days prior to the first day of the meeting of the House of Delegates.

CHAPTER 11
MEMBERSHIP IN COMPONENT SOCIETIES

Section 1 — Qualifications for membership in a Component Society. To be eligible for active membership, MULTI-COUNTY MEMBERSHIP, associate membership or in training membership in a component society, or other probationary or provisional type of membership of limited duration, a person must possess all of the following qualifications:

(a) He must meet all those requirements for membership in this Association which are enumerated in Section 3 of Chapter 1, hereof, and at the time of making application to the component society shall tender the appropriate Ohio State Medical Association dues and assessments for the current year. MULTI-COUNTY MEMBERS SHALL TENDER OHIO STATE MEDICAL ASSOCIATION DUES THROUGH THE COMPONENT SOCIETY OF PRIMARY MEMBERSHIP; FOR ALL OTHER COMPONENT SOCIETY MEMBERSHIPS, MULTI-COUNTY MEMBERS SHALL TENDER THE DUES OWED TO THAT SOCIETY FOR LOCAL MEMBERSHIP FOR THE CURRENT YEAR;

(b) He must be a bona fide resident of, or must conduct ~~the major~~ a portion of his practice in, the county in which such component society is located. PROVIDED, HOWEVER, THAT WHERE A MULTI-COUNTY MEMBER WISHES TO CHANGE THE COMPONENT SOCIETY DESIGNATED AS THE SOCIETY OF PRIMARY MEMBERSHIP, HE MAY DO SO, BUT SUCH CHANGE WILL NOT BE EFFECTIVE UNTIL THE NEW CALENDAR YEAR. ~~Provided, however, that where it is more convenient for a member of a component society to attend the meetings of another component society located in a county adjoining that in which he hold such membership, such member, upon application to, and approval by, both the society in which he holds such membership and the society in such adjoining county, shall be entitled to a transfer of his membership to the latter society; and, provided further, that no person possessing an active membership, associate membership, or in training membership, or probationary or provisional type of membership, of limited duration, in one component society may acquire or possess at the same time an active membership, or an associate or probationary or provisional type of membership of limited duration, in another component society.~~

As used in this Section 1, "active membership" in a component society means any type of membership having voting and office-holding rights and privileges.

Subject to the provisions of the foregoing paragraphs of this Section 1, each component society shall be the sole judge of the qualifications necessary for any and all classes of membership in such society.

Section 2 — Roster of Members. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary by Council.

MULTI-COUNTY SOCIETY

MEMBERS SHALL BE DESIGNATED SEPARATELY, WITH THE COMPONENT SOCIETY OF PRIMARY MEMBERSHIP CLEARLY IDENTIFIED.

Proposed Council Resolution C — Establishment of a Resident Physician's Section Within the OSMA

WHEREAS, The number of AMA and OSMA resident physician members has been steadily increasing; and

WHEREAS, More and more resident physicians are becoming active in their Housestaff Associations, county medical societies, and in the broader aspects of organized medicine; and

WHEREAS, The AMA Resident Physician's Section has become a strong and vital member of the AMA House of Delegates with full voting privileges and a position on the AMA Board of Trustees; and

WHEREAS, There is a need for continuous and active communication between the various aspects of the medical profession to assure a strong medical society, ready to meet the ongoing challenges of our changing times; therefore be it

RESOLVED, That a Resident Physician's Section within the OSMA be formed to provide a forum within the state association for the exchange of information among young physicians in training and their Senior colleagues; and be it further

RESOLVED, That Article IV of the OSMA Constitution be amended by inserting a new part (4) as follows:

The House of Delegates shall be the legislative body of this Association and shall consist of: (1) delegates elected by the component societies; (2) officers of the Association enumerated in Article VI; (3) such representatives of other medical groups as may be determined by the House of Delegates; The Medical Student Section shall have six representatives to the House of Delegates commencing with the Annual Meeting in 1982, said delegates to be selected in accordance with the Bylaws of the Medical Student Section to be approved by Council.

For purposes of representation in the House of Delegates, student members shall not be counted at the individual district level, but shall constitute a separate section which shall be treated and seated as if it were an additional district in which the student members of each medical school elect their own delegate; the Hospital Medical Staff Section shall have one representative to the House of Delegates commencing with the Annual Meeting in 1985, said delegate to be selected in accordance with Bylaws of the Medical Staff Section to be approved by Council *(4)* THE RESIDENT PHYSICIAN'S SECTION SHALL HAVE ONE REPRESENTATIVE WHO MUST BE A MEMBER IN TRAINING OF THE OSMA, SAID REPRESENTATIVE TO BE SELECTED IN ACCORDANCE WITH THE RESIDENT SECTION BYLAWS TO BE APPROVED BY COUNCIL; ~~(4)~~ (5) delegates and alternate delegates to the American Medical Association from Ohio. Past Presidents and Past Councilors of this Association each of whom shall be an ex-officio member without right to vote unless such delegate, alternate delegate or past president be a duly elected delegate from a component society or a duly elected officer of this Association; and be it further

RESOLVED, That Chapter 4 of the Bylaws be amended by inserting a new Section 4 as follows: Section 4. *Resident Section* THE RESIDENT SECTION SHALL HAVE ONE DELEGATE AND ONE ALTERNATE DELEGATE WHO MUST BE MEMBERS IN TRAINING OF THE OSMA. THE RESIDENT PHYSICIAN SECTION'S DELEGATE SHALL HAVE ALL THE RIGHTS, PRIVILEGES, AND DUTIES OF OTHER DELEGATES. THE DELEGATE WILL BE SEATED IN THE HOUSE OF DELEGATES WITH COUNCILOR DISTRICT IN WHICH HIS/HER COUNTY medical society is represented (and renumber the remaining sections)
Section ~~(4)~~ 5. Representative of Hospital Medical Staff Section.
Section ~~(5)~~ 6. Quorum.
Section ~~(6)~~ 7. Committees of the House of Delegates.
Section ~~(7)~~ 8. Delegates to the American Medical Association.
Section ~~(8)~~ 9. Councilor Districts.
Section ~~(9)~~ 10. Special Committees.
Section ~~(10)~~ 11. Resolutions.
Section ~~(11)~~ 12. Order of Business.; and be it further

RESOLVED, That the OSMA Constitution, Article VII, be amended as follows:

The Council shall consist of one councilor from each councilor district. ONE NON-VOTING COUNCILOR FROM THE RESIDENT PHYSICIAN'S SECTION, one non-voting student member from the Medical Student Section and the other elected officers of this Association. The Council shall be the executive body of this Association and it shall have the complete custody and control of all funds and property of this Association and shall have and exercise full power and authority of the House of Delegates between meetings of the House of Delegates; and be it further

RESOLVED, That the OSMA Bylaws Chapter 7, Section ("Individual Duties of Councilors") shall be amended as follows:

Each Councilor shall be the organizer, peacemaker and censor for his district. He shall visit each county in his district at least once each year for the purposes of inquiring into the condition of the profession and of each component society in his district and of keeping in touch with the activities of each of such societies. In every disciplinary matter involving a member of a component society located in the Councilor's district, the Councilor, in advance of a hearing on any charges filed against such member, shall make every effort to effect a conciliation or compromise consistent with honor and the principles of medical ethics. The duties of the non-voting Councilor from the Medical Student Section shall be set forth in the Bylaws of said section. THE DUTIES OF THE COUNCILOR FROM THE RESIDENT PHYSICIAN'S SECTION SHALL BE SET FORTH IN THE BYLAWS OF SAID SECTION WHICH SHALL BE APPROVED BY THE COUNCIL. **OSMA**

Medical Liability Tort Reform

Physician Action Needed

By the OSMA Department of Legislation

Medical Liability Reform Remains Priority

The priority piece of legislation for the 117th Ohio General Assembly is OSMA's medical professional liability reform measure. This bill, soon to be introduced by State Representative Paul Jones (D-Ravenna), is substantially the same bill as House Bill 1025, which was considered late in the last session of the General Assembly.

While the legislature's failure to act on House Bill 1025 in 1986 was disappointing, it came as no surprise since legislative leaders had indicated from the beginning that they preferred to postpone debate on medical professional liability until the legislature resolved the general tort and insurance reform bill, Senate Bill 330. Senate Bill 330, which deals with the more global issues of commercial and professional liability, finally passed the legislature on the last night of session in 1986, but was vetoed by the Governor.

Governor Celeste's veto of House Bill 330 made it necessary for the reintroduction of a general tort and insurance reform bill in 1987. House Bill 1 (Stinziano, D-Columbus) and Senate Bill 11 (Snyder, R-Hillsboro), two bills identical to the vetoed bill, have been introduced in the new session. Passage of House Bill 1 by the Ohio House of Representatives sets the stage for the legislature to tackle medical professional liability in early 1987 and to resolve the growing medical liability insurance problems facing Ohio physicians.

The need for professional liability reform is not new to Ohio physicians or to the members of the Ohio General Assembly. In 1975 the legislature stepped in to resolve the medical malpractice crisis that threatened physicians and patients alike. House Bill 682, supported by OSMA, passed in 1975 and stabilized the medical professional liability market for a brief period. However, as most physicians know from their own personal experience, much has happened in the ensuing 11 years to weaken the Ohio law resulting from House Bill 682, and thus has created the need for new medical professional liability reform legislation.

In the 11 years since the passage of House Bill 682, the Ohio Supreme Court has eroded the intent of the medical professional liability statutes. This is particularly true in regard to the Court's treatment of the statute of limitations for medical claim cases. There has also been increasing tendency for juries and courts to grant large awards in medical claim cases.

In the current 117th General Assembly, the health care groups which originally endorsed House Bill 1025, the Ohio State Medical Association, the Ohio Hospital Association and the Ohio Osteopathic Association, continue to work together to assure that medical liability is addressed. A broad base of other health care providers and other groups involved in the health care arena are expected to join in the effort to enact medical liability reform.

State Representative Paul Jones, Chairman of the House Health and Retirement Committee, is the bill's chief sponsor in the Ohio House of Representatives. His grasp of this difficult issue and his aggressive support will help give medicine the advantage it needs to make this effort successful. The OSMA will be seeking the support of as many legislators as possible

in the campaign to enact medical professional liability reform.

Medicine will have several other advantages this time around which will also help assure success. First of all, thanks to the hard work of State Representative Jones and the testimony presented to date, Ohio legislators are much better acquainted with the various aspects of medical professional liability and its implication for the future. Physicians must contact local legislators to reinforce the priority of enactment of medical professional liability reform.

Secondly, the OSMA has been developing statistical evidence to support its claims that Ohio is facing a potential "malpractice" crisis and that the need to pass reform before a crisis similar to the malpractice crisis of 1975 is upon us. This information is vital to counter the claims of various groups (i.e., Ohio Academy of Trial Lawyers and Nader groups) that the liability crisis has been manufactured by the insurance industry. These groups are the primary opponents to medical professional liability statute reforms.

The OSMA, Ohio Hospital Association, Ohio Osteopathic Association Coalition contracted in the fall with the nationally recognized accounting firm of Tillinghast, Nelson and Warren, Inc., to gather data on the medical liability climate in Ohio. Representatives of Tillinghast report that there has been a sharp increase in the severity of claims filed against physicians in Ohio. From 1981 to 1985, total payments by insurance companies to cover claims against Ohio physicians have increased by 46% annually while nationally the increase is 23%.

Tillinghast also reports that, during the same time frame, the frequency of claims filed against physicians increased at the rate of 13% annually. From 1980 to 1984

Major Elements of Medical Liability Reform

OSMA's medical professional liability bill will address those areas of Ohio tort statutes which are in the most need of reform in order to ensure the predictability needed for affordable and available medical professional liability insurance. The OSMA intends to actively pursue enactment of the medical professional liability reform bill in the 117th Ohio General Assembly. The following is a brief analysis of the major provisions of the legislation.

A central provision of the bill is the statute of limitations which would apply to any medical or dental claim brought against a physician, nurse, dentist, podiatrist or hospital or its employees or agents. The bill requires that a lawsuit be brought within one year from the time the patient discovers or should have discovered the injury. There is, however, an absolute bar to bringing a suit four years from the date the act or omission occurs.

The medical liability bill also proposes to reduce the number of frivolous suits filed in medical malpractice cases by establishing a procedure for filing an affidavit with the complaint. The affidavit would declare that a physician has reviewed the medical record and has found the medical claim to be reasonable. If the statements in the claim are found to be without reasonable cause and untrue, then the plaintiff and the plaintiff's attorney can be liable to pay for the physician's attorney's fees.

The collateral source proposal in the bill would expand current collateral source statutes pertaining to medical claims to specify that damages awarded would be reduced by any payments made by any collateral source (e.g., Medicare, Medicaid, Worker's Compensation, Blue Cross/Blue Shield).

The bill would establish a procedure for the itemization of awards and, in any case where future damages awarded for both economic and non-economic loss exceed $100,000, a procedure for periodic payments to be set by the court, if requested by either party to the suit. The bill would also require that at the death of the plaintiff, all future payments would cease.

The revision of the doctrine of joint and several liability is addressed in the bill.

The bill would establish a contingency fee schedule for granting of attorney's fees to the plaintiff's attorney. This schedule would gauge the attorney's fee for the case to the amount of award made to the plaintiff in the case. — *Legislative staff*

Please Contact Your Legislators

Physicians are requested to contact their state representative and senator to emphasize the need for medical professional liability reform early in the current session. Physicians should request support of the OSMA medical liability proposal and encourage legislators to sign on as co-sponsors.

Below is the proper way to address correspondence to a state senator or representative:

The Honorable _____

Ohio Senate
State House
Columbus, Ohio 43216

or

Ohio House of Representatives
State House
Columbus, Ohio 43216

If you have any questions or are in need of additional information, please contact the OSMA Department of Legislation. — *Legislative staff*

the average number of claims filed against physicians almost doubled from 1.4 claims to 2.3, and if increases continue to accumulate at 13% annually, the number of claims filed against physicians will double again in less than six years! These are averages for all physician specialties; however, obstetricians, gynecologists, anesthesiologists, and neurosurgeons have experienced the most dramatic claims increases and therefore the sharpest rises in their premiums.

Tillinghast experts conclude that total Ohio premiums for malpractice insurance had increased from 1981 to 1985 at an aggregated annual rate of 16.4%. The largest increase of 47% came in 1985 as insurance companies scrambled to respond to the alarming recent increases in claims frequency and severity. From this evidence, it is clear that increases similar to those of 1985 may be in store for the future without meaningful reform of Ohio medical professional liability laws.

State Representative Jones says this time around, he feels the medical professional liability bill will pass, adding that he plans to make it a top priority. "As a State Representative one of my goals is to assure that Ohioans have access to affordable, high quality health care. The pending medical liability crisis will threaten the affordability, accessibility and quality of health care in this state. We must not let this happen. This problem must be addressed." **OSMA**

MOVING

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Angioplasty Update '87

A Demonstration Course
April 10-11, 1987 Charleston, West Virginia

This two-way interactive course will feature a live case demonstration of percutaneous transluminal coronary angioplasty (PTCA) as an alternative treatment of patients with coronary heart disease.

Featured Speakers:
Gary S. Roubin, M.B., Ph.D.
Emory University
School of Medicine

Eric J. Topol, M.D.
University of Michigan
School of Medicine

Topics Include:
Indications and Contraindications, Results, Newer Technology and Acute Intervention.

For more information contact CAMC's Department of Continuing Education, Charleston Area Medical Center 3110 MacCorkle Avenue, S.E. Charleston, W.Va. 25304 Or call (304) 348-9580.

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Proceedings of the Council

November 15, 1986

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, November 15, 1986 at the OSMA Headquarters, 600 South High Street, Columbus, Ohio.

Those present were:
John E. Albers, MD, Cincinnati
D. Ross Irons, MD, Bellevue
Herman I. Abromowitz, MD, Dayton
Joseph Sudimack, Jr., MD, Warren
Stanley J. Lucas, MD, Cincinnati
William J. Marshall, MD, Dayton
Thomas R. Leech, MD, Lima
John A. Devany, MD, Toledo
Donavin A. Baumgartner, Jr., MD, Cleveland
J. James Anderson, MD, Youngstown
Nermin D. Lavapies, MD, Martins Ferry
John F. Kroner, Jr., MD, Athens
Thomas P. Price, Jr., MD, Gallipolis
H. William Porterfield, MD, Columbus
Charles G. Adams, MD, Vermilion
Joseph L. Kloss, MD, Akron
Brian F. Jewell, Toledo, President Medical Student Section
Oscar W. Clarke, MD, Gallipolis, Chm. AMA Delegation
Nora Feezel, Canton, President OSMA Auxiliary
Kurt Driscoll, Columbus, President Professionals Insurance Company
Thomas J. Halpin, MD, Columbus, Director Ohio Department of Health
Warren Ljungren, MD, Dayton, Chm. Resident Physicians Committee
Ray W. Gifford, Jr., MD, Cleveland, AMA Board of Trustees
Edmond W. Gardner, MD, Columbus, President Ohio Dermatological Society
William H. Gates, MD, Cincinnati, Chm. Committee on Emergency & Disaster Medical Care

Those present from OSMA staff:
Herbert E. Gillen
D. Brent Mulgrew, Esq.
Jerry J. Campbell
Robert D. Clinger
Katherine E. Wisse
Gail E. Dodson
David C. Torrens
Carol W. Mullinax
Catherine M. Costello, Esq.
William E. Fry
Carolyn H. Towner
Kent Studebaker
Doug Graff, Esq.
John Van Doorn
Rick Ayish
David W. Pennington
Doug Evans

The meeting was opened with a moment of silence in memory of Mrs. Jeanne Devany.

Dr. Albers introduced Edmond Gardner, MD, President of the Ohio Society of Dermatology, an invited guest.

President's Report

Dr. Albers reported on his visits to the annual meetings of the Kentucky Medical Association and the Pennsylvania Medical Society and the many district legislative meetings he attended.

He reported many favorable comments have been received regarding his letter in the OSMAgram reviewing the PPO contract of Community Mutual Insurance Company.

Dr. Albers expressed concern about a trend that is developing across the country of tieing medical licensure to requirements other than a physician's ability to practice medicine, such as whether or not assignment is taken under Medicare or a certain number of risk management courses have been taken.

Previous Minutes

Minutes of the September 12-13, 1986 meeting of the Council and the November 5, 1986 telephonic meeting of the Council were approved as distributed.

Executive Director's Report

Mr. Gillen reported Peer Review Systems, Inc. of Columbus had been awarded the contract by HCFA to be PRO for Ohio. He reported the renewal was not automatic and that the new two-year contract for $11.2 million is a 17% decrease from the previous two-year contract. Mr. Gillen stated that at a recent meeting of state medical association CEOs, much concern was expressed about the activities of the PROs and the requirements HCFA is placing on them.

Also discussed were meetings staff have conducted with the county executives.

Mr. Gillen complimented Dr. Baumgartner and Dr. Abromowitz

for their excellent presentations at the Lorain County Medical Society on why physicians should belong to the AMA and OSMA.

Director of Health Report

Thomas Halpin, MD, Director of the Ohio Department of Health, reported the Department continues to focus much attention on the issue of AIDS. He reported that blood banks were involved in a "look back" program, to review old records and notify blood recipients if they had received blood donated by someone who subsequently developed AIDS. Dr. Halpin stated there are 30,000 to 40,000 in Ohio who could be infected with the AIDS virus according to Department projections.

Dr. Halpin also discussed current legislative activities of the Department regarding health planning since federal health planning funds were withdrawn as of October 1, 1986.

Legislation

Dr. Marshall presented the minutes of the November 14, 1986 meeting of the Committee on State Legislation which were accepted for information. Dr. Marshall and the legislative staff updated Council on the current status of H.B. 494-IPA Mandated Providers; H.B. 1025-Medical Malpractice, and H.B. 769-Medical Board Reform.

Mr. Ayish discussed the election results and the possible impact in the 117th General Assembly and the Ohio Supreme Court.

Medical Board Report

Cathy Costello and Doug Graff reported on current activities of the Ohio State Medical Board which included the Board's release of new rules for the dispensing of amphetamines for weight loss. It was reported the Board will send a copy of these rules to physicians in January with medical relicensing material and that staff would prepare a synopsis of these new rules for inclusion in the December OSMAgram.

Auditing and Appropriations Committee Report

Dr. Baumgartner, Chairman, presented the minutes of the November 14, 1986 meeting of the Committee on Auditing and Appropriations. On recommendation of the Committee, the Council took the following actions:

- Approved the 1987 revenue budget of $4,314,388.00.
- Approved the 1987 expense budget of $4,266,861.00 (which includes adjustments in officers' honorariums).
- Reserved the $50,000 unused in the 1986 Furniture and Equipment budget for the Cash Fund Restricted for Replacement of Assets.
- Accepted the 1985 audit.
- Approved the Treasurer's report.

Committee Reports

The Council accepted for filing the following Committee reports:

- Ohio Medical Education and Research Foundation — September 14, 1986
- Task Force on Professional Liability — September 20, 1986
- Committee on Emergency and Disaster Medical Care — October 9, 1986. Dr. William Gates, Chairman, presented a status report on the implementation of Substitute Resolution 20-86 "Criteria for Categorizing Hospitals for Management of Trauma."
- OSMA/MSS Governing Council Meeting — October 12, 1986

Gail Dodson presented the 1987 Annual Meeting format which was accepted for information. The Council passed a motion requiring all candidate interviews at the Annual Meeting be conducted on Saturday afternoon from 2:30-5:00 p.m. with the Sunday morning time being reserved to consider Resolution Committee reports.

The Council further directed the Committee on Education to study the feasibility of extending the Annual Meeting to four days and holding the Annual Meeting in Columbus every year.

Committee Reports Requiring Action

The Council took the following actions on recommendation of the Committee on Education which met on September 17, 1986 and November 7, 1986:

- Approved "Clinical Update" for the theme for the 1987 Scientific meeting
- Approved the proposed budget for the 1987 scientific meeting
- Approved a revised mission statement regarding continuing medical education
- Approved that the filing of the application for joint sponsorship for CME-1 credit be received no less than three months prior to the date of the program

The Council took the following actions recommended by the Ad Hoc Committee to Review OSMA House of Delegates Policy which met on October 2, 1986:

- Approved the Committee's recommendation that the

In mild to moderate hypertension
THE FIRST ONCE DAILY
CALCIUM CHANNEL BLOCKER

Brief Summary

ISOPTIN® SR
(verapamil HCl/Knoll)
240 mg scored, sustained-release tablets

CONTRAINDICATIONS: 1) Severe left ventricular dysfunction (see WARNINGS), 2) Hypotension (less than 90 mmHg systolic pressure) or cardiogenic shock, 3) Sick sinus syndrome or 2nd or 3rd degree AV block (except in patients with a functioning artificial ventricular pacemaker).

WARNINGS: Heart Failure: ISOPTIN should be avoided in patients with severe left ventricular dysfunction (see DRUG INTERACTIONS). Patients with milder ventricular dysfunction should, if possible, be controlled before verapamil treatment. Hypotension: ISOPTIN (verapamil HCl) may produce occasional symptomatic hypotension. Elevated Liver Enzymes: Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Periodic monitoring of liver function in patients receiving verapamil is therefore prudent. Accessory Bypass Tract (Wolff-Parkinson-White): Patients with paroxysmal and/or chronic atrial flutter or atrial fibrillation and a coexisting accessory AV pathway have developed increased antegrade conduction across the accessory pathway producing a very rapid ventricular response or ventricular fibrillation after receiving intravenous verapamil. While this has not been reported with oral verapamil, it should be considered a potential risk. Treatment is usually D.C.-cardioversion. Atrioventricular Block: The effect of verapamil on AV conduction and the SA node may cause asymptomatic 1st degree AV block and transient bradycardia. Higher degrees of AV block, while infrequent (0.8%), may require a reduction in dosage or, in rare instances, discontinuation of verapamil HCl. Patients with Hypertrophic Cardiomyopathy (IHSS): Although verapamil has been used in the therapy of patients with IHSS, severe cardiovascular decompensation and death have been noted in this patient population.

PRECAUTIONS: Impaired Hepatic or Renal Function: Verapamil is highly metabolized by the liver with about 70% of an administered dose excreted in the urine. In patients with impaired hepatic or renal function verapamil should be administered cautiously and the patients monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacological effects (see OVERDOSAGE).

Drug Interactions: Beta Blockers: Concomitant use of ISOPTIN and oral beta-adrenergic blocking agents may be beneficial in certain patients with chronic stable angina or hypertension, but available information is not sufficient to predict with confidence the effects of concurrent treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities. Digitalis: Clinical use of verapamil in digitalized patients has shown the combination to be well tolerated if digoxin doses are properly adjusted. However, chronic verapamil treatment increases serum digoxin levels by 50 to 75% during the first week of therapy and this can result in digitalis toxicity. Upon discontinuation of ISOPTIN (verapamil HCl), the patient should be reassessed to avoid underdigitalization. Antihypertensive Agents: Verapamil administered concomitantly with oral antihypertensive agents (e.g., vasodilators, angiotensin-converting enzyme inhibitors, diuretics, beta blockers, prazosin) will usually have an additive effect on lowering blood pressure. Patients receiving these combinations should be appropriately monitored. Disopyramide: Disopyramide should not be administered within 48 hours before or 24 hours after verapamil administration. Quinidine: In patients with hypertrophic cardiomyopathy (IHSS), concomitant use of verapamil and quinidine resulted in significant hypotension. There has been a report of increased quinidine levels during verapamil therapy. Nitrates: The pharmacologic profile of verapamil and nitrates as well as clinical experience suggest beneficial interactions. Cimetidine: Two clinical trials have shown a lack of significant verapamil interaction with cimetidine. A third study showed cimetidine reduced verapamil clearance and increased elimination to 1/2. Anesthetic Agents: Verapamil may potentiate the activity of neuromuscular blocking agents and inhalation anesthetics. Carbamazepine: Verapamil may increase carbamazepine concentrations during combined therapy. Rifampin: Therapy with rifampin may markedly reduce oral verapamil bioavailability. Lithium: Verapamil may lower lithium levels in patient on chronic oral lithium therapy. Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no evidence of a carcinogenic potential of verapamil administered to rats for two years. Verapamil was not mutagenic in the Ames test. Studies in female rats did not show impaired fertility. Effects on male fertility have not been determined. Pregnancy (Category C): There are no adequate and well-controlled studies in pregnant women. ISOPTIN crosses the placental barrier and can be detected in umbilical vein blood at delivery. This drug should be used during pregnancy, labor, and delivery, only if clearly needed. Nursing Mothers: ISOPTIN is excreted in human milk, therefore, nursing should be discontinued while verapamil is administered. Pediatric Use: Safety and efficacy of ISOPTIN in children below the age of 18 years have not been established.

ADVERSE REACTIONS: Constipation 8.4%, dizziness 3.5%, nausea 2.7%, hypotension 2.5%, edema 2.1%, headache 1.9%, CHF/pulmonary edema 1.8%, fatigue 1.7%, bradycardia 1.4%, 3° AV block 0.8%, flushing 0.1%, elevated liver enzymes (see WARNINGS). The following reactions, reported in less than 1.0% of patients, occurred under conditions (open trials, marketing experience) where a causal relationship is uncertain; they are mentioned to alert the physician to a possible relationship: angina pectoris, arthralgia and rash, AV block, blurred vision, cerebrovascular accident, chest pain, claudication, confusion, diarrhea, dry mouth, dyspnea, ecchymosis or bruising, equilibrium disorders, exanthema, gastrointestinal distress, gingival hyperplasia, gynecomastia, hair loss, hyperkeratosis, impotence, increased urination, insomnia, macules, muscle cramps, myocardial infarction, palpitations, paresthesia, psychotic symptoms, purpura (vasculitis), shakiness, somnolence, spotty menstruation, sweating, syncope, urticaria. Treatment of Acute Cardiovascular Adverse Reactions: Whenever severe hypotension or complete AV block occur following oral administration of verapamil, the appropriate emergency measures should be applied immediately, e.g., intravenously administered isoproterenol HCl, levarterenol bitartrate, atropine (all in the usual doses), or calcium gluconate (10% solution). If further support is necessary, inotropic agents (dopamine or dobutamine) may be administered. Actual treatment and dosage should depend on the severity and the clinical situation and the judgment and experience of the treating physician.

OVEROOSAGE: Treatment of overdosage should be supportive. Beta-adrenergic stimulation or parenteral administration of calcium solutions may increase calcium ion flux across the slow channel, and have been used effectively in treatment of deliberate overdosage with verapamil. Clinically significant hypotensive reactions or fixed high degree AV block should be treated with vasopressor agents or cardiac pacing, respectively. Asystole should be handled by the usual measures including cardiopulmonary resuscitation.

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following resolutions adopted at the 1983 OSMA Annual Meeting be retained:

- 6-83 Workmen's Compensation Disability Determinations
- 17-83 Control of Look-alike Drugs and Over-the-Counter Drug Abuse
- 18-83 Prescription Abuse
- 20-83 Handicapped Children
- 21-83 Problems of the Senior Citizens
- 30-83 Therapeutic Substitution
- 31-83 Drug Availability
- 32-83 Support of Ohio Medical Education and Research Foundation
- 38-83 Contraceptive Devices for Minors
- 39-83 Corporal Punishment in Schools
- 41-83 Boxing as a Health Hazard
- 42-83 Ohio State Medical Board
- 43-83 Sexual Harassment

• Approved the Committee's recommendation that the following resolutions adopted at the 1983 OSMA Annual Meeting not be retained:

- 1-83 Informational Programs by Pharmaceutical Companies and Medical Appliance Manufacturers
- 2-83 Proposed Revisions of JCAH Standards
- 7-83 Inequities in Third Party Reimbursement
- 9-83 Cost Containment in Medical Care
- 11-83 Commending E. Joel Davis
- 22-83 Vision Testing for Drivers
- 23-83 Repeal of 1974 Health Planning Act — P.L. 93-641
- 24-83 Proposed Regulations for Non-Physicians
- 26-83 Wrongful Death Statute
- 27-83 OSMA Auxiliary Commendation

IMAGINE A MACHINE THAT CAN DO THIS TO RENAL CALCULI

We're proud to announce the introduction of Extracorporeal Shock Wave Lithotripsy as a new feature of our kidney stone treatment program. This new device makes it possible to pulverize and eliminate kidney stones without invasive surgery. Now you have the opportunity to participate in this state-of-the-art procedure at CAMC's High Tech Center here in Charleston, West Virginia.

The Lithotripter uses shock waves to bombard kidney stones into sand-like particles inside the body. The residue is then easily passed. Although the theory behind Lithotripsy is simple, the process is precise. The stone is pinpointed inside the body with fluoroscopy and shock wave firing is synchronized with the patient's heartbeat by electrocardiogram. Usually, the entire process takes about an hour.

As you can imagine, Lithotripsy offers many benefits to kidney stone patients. The process is less painful, entails fewer side effects, and recuperation is quicker than with conventional surgery. It's even less expensive than surgery.

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28-83 Physician Manpower
- Report A, Res. 12-82, Authority for Peer Review Functions
- Report B, Report of the Ad Hoc Committee to Review House of Delegates Policy
- Approved giving the Committee the responsibility to review all retained policy from 1929-1982, to rewrite resolutions as needed and to prepare a comprehensive report for the Council to consider in making recommendations to the 1988 House of Delegates.

The Council approved the recommendation of the Resident Physicians Committee, which met on October 4, 1986, that one or two physicians or OSMA Councilors be appointed to the Committee as advisors. Dr. Ljungren, Chairman, reported the Committee has under discussion the feasibility of developing a newsletter for residents.

The Council took the following actions regarding recommendations of the Committee on Membership which met October 8, 1986:
- Approved communicating to all Ohio Foreign Medical Graduates (members and nonmembers) the contents of AMA Resolution 56 (A-86) and a summary of Board of Trustees Report Z.
- The Council modified and then approved the recommendation that a new membership category be created for married couples with annual dues for the two members to be 150% of one full dues payment. Each Councilor was asked to ascertain the impact of this action based on local data.

The Council approved the recommendation of the Journal Advisory Committee, which met on October 22, 1986, that the name of the "Ohio State Medical Journal" be changed to "Ohio Medicine — The Journal of the Ohio State Medical Association."

The Council postponed action on a recommendation of the Communications Committee, which met on October 15, 1986, asking that "Synergy" be renamed. The Council will reconsider this recommendation when a suitable name is proposed.

AMA Activities Report

Dr. Clarke, Chairman of the Ohio Delegation to the AMA, reported the delegation would be meeting prior to the AMA Interim meeting to study the resolutions and reports that will be introduced to the House of Delegates. He reported Edwin Meese, U.S. Attorney General, would address the House.

Ray Gifford, MD, AMA Board of Trustee member, highlighted recent accomplishments of the AMA with Congress. He further reported there will be major changes in the planning and direction of the AMA. Also reported was the involvement of the AMA in the development of a relative value scale for reimbursement of physician services under Medicare.

Medical Payment Systems

Mr. Pennington reported on the current status of the staff's study of the AMA/MPS. The report was received for information.

Mr. Pennington also reported on the Alliance of State Physician Networks. It was Council action that the OSMA continue to monitor this alliance and its activities.

Auxiliary Report

Mrs. Nora Feezel discussed the current and future activities of the OSMA Auxiliary.

New Business

The Council voted to study OSMA investment policies as related to those companies doing business with South Africa and referred to the Auditing and Appropriations Committee for implementation.

The Council approved investigating physician groups that are being organized to deal with the changes that are occurring in medical practices.

The Council approved the creation of a Task Force on Health Planning to study and provide direction on Certificate of Need.

Old Business

Dr. Irons reported on a meeting the officers and Dr. Henry had with representatives of the Ohio Hospital Insurance Company regarding the $1,000,000 malpractice insurance coverage requirement for hospital medical staff membership. Dr. Irons reported the meeting was less than satisfactory.

The Council reaffirmed OSMA policy that the Director of the Ohio Department of Health be a physician.

Meeting adjourned.

Respectfully submitted,
Herbert E. Gillen
Executive Director

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RESISTANT DUODENAL ULCERS

Thomas A. LoIudice, DO, FACG
David Kogut, MD

A prospective multi-center study of duodenal ulcer patients treated with cimetidine after failing to heal with ranitidine is presented. Of the 16 ranitidine failures thus encountered, nine ulcers subsequently healed after six weeks treatment with cimetidine. It is concluded that ulcers which fail to heal with one H_2-receptor antagonist may respond to another.

Introduction

As is the case with any therapeutic regimen for peptic ulcer, treatment with histamine H_2 receptor antagonists (H_2RA) does not result in 100% healing. Most studies report successful healing in about 80% of cases after four weeks of therapy with an H_2RA. This figure increases with continued therapy, reaching over 90% in three months.[1-2]

The question has been raised as to whether an ulcer resistant to one H_2RA might be responsive to another. Previous reports have been characterized by a lack of uniformity of the definition of a resistant ulcer, and, in addition, a variety of clinical situations were represented that introduced a number of variables that may have contributed to non-healing.

The purpose of the present study was to determine whether duodenal ulcers that had not healed on ranitidine therapy would respond to a course of cimetidine.

Thomas A. LoIudice, DO, FACG, St. Thomas Medical Center, Northeastern Ohio Universities College of Medicine, Akron. David Kogut, MD, David Community Hospital and Iredell Memorial Hospital, Statesville, North Carolina.

Methodology

Adult outpatients in whom a duodenal ulcer (grade 4) was documented by endoscopy (see below), and who had ulcer-related symptoms in at least three of the seven days prior to entry were eligible for inclusion. Excluded were pregnant women or patients with alcoholism, Zollinger-Ellison Syndrome, gastric ulcers, previous gastric surgery, abnormal laboratory values or those on long-term non-steroidal anti-inflammatory drug (NSAID) therapy.

All patients were treated initially with the full recommended course of treatment with ranitidine (150 mg twice daily, for four weeks). Those patients who were resistant to the full course of ranitidine therapy (i.e. whose ulcers were still present at endoscopy at four weeks) entered the second phase of the study and were treated with the full recommended course of cimetidine (300 mg four times daily for six weeks). Concomitant low dose antacid therapy was allowed only during the first week of ranitidine treatment. Patients were specifically instructed not to take antacids of any kind during the last three weeks of ranitidine therapy or during any of the cimetidine treatment. Subjects were clinically assessed at two week intervals while on either H_2-receptor antagonist and at the end of the treatment periods at which time endoscopy was repeated and the duodenal mucosa was graded utilizing the following classification: Grade 1 — normal; grade 2 — hyperemia; grade 3 — erosion, defined as a discontinuity of the epithelium without a definite crater formation; grade 4 — defined as a discontinuity of the epithelium with definite crater formation. Symptomatic relief was assessed by measuring the number of days and/or nights with pain and by the severity of both daytime and nighttime pain.

Table I

Patient Characteristics — Phase I

Number in Trial (male/female)	35 (17/18)
Age (years)	
Mean	45.5
Range	23-75
Cigarette smokers (%)	42.9%
Male	10
Female	5
20 cigarettes/day (%)	31.4%

Patient Characteristics — Phase II

Number in Trial (male/female)	16 (9/7)
Age (years)	
Mean	48.2 (±)
Range	25-65
Cigarette smokers (%)	56.3%
Male	7 (77.7%)
Female	2 (28.6%)
10 cigarettes/day (%)	31.3%

All adverse experiences that occurred during the course of the study were recorded and graded in severity from mild to severe. Laboratory parameters were measured at the preliminary examination prior to treatment, at weeks two and four during ranitidine treatment, and at week six for patients being treated with cimetidine.

A total of 35 patients (17 males and 18 females) entered the study and were treated with ranitidine. Table 1 lists the demographic characteristics of the patients. Their ages ranged from 23 to 75 years with a mean of 45.5 years. Fifteen of the patients (43%) were smokers (defined as those using more than ½ package of cigarettes per day); eleven (31%) smoked more than 20 cigarettes per day.

Results

Of the 35 patients treated with ranitidine, 19 (54.3%) had endoscopic evidence of ulcer healing after four weeks of ranitidine (Table II). The 16 patients whose ulcers were resistant to ranitidine treatment, i.e. failed to heal, were entered into treatment with cimetidine. Table I lists the characteristics of these 16 patients. Nine of this group (56%) were smokers. Their ages ranged from 25 to 65 years with a mean age of 48.2 years.

After six weeks of cimetidine therapy all patients showed improvement in their endoscopic findings. Nine (56%) of the ranitidine failures were healed (Table II) and the remainder had erosions but no ulcer on endoscopy. The results of symptomatic relief for each phase are detailed in Tables II and III. Of the 35 patients on ranitidine therapy, 15 (42%) became asymptomatic after one week of therapy and 22 (63%) were symptom-free at four weeks, the conclusion of therapy. Of the 16 ranitidine resistant patients, four additional patients (25%) were symptom-free after one week of cimetidine. Seven patients (42.5%) were asymptomatic after four weeks and 10 (62.5%) were symptom-free after six weeks of cimetidine. Thus, after the total therapeutic regimen, 32 of 35 (91%) were asymptomatic.

Three side effects possibly attributed to study medication were noted during the trial. One patient complained of severe headaches during the last two weeks of ranitidine therapy. Another patient developed a rash during the final three days of ranitidine therapy which resolved while on cimetidine therapy. A 50-year-old male experienced impotence 11 days after initiation of cimetidine therapy which rapidly disappeared following the cessation of therapy. No laboratory abnormalities attributed to either study drug were noted.

Discussion

It has been repeatedly shown that ranitidine 150 mg. twice a day and cimetidine 300 mg. four times a day are equally efficacious in the treatment of duodenal ulcers in four weeks.[1,2,3] Longer courses of treatment with either medication may increase healing percentages. The approach to the ulcer that fails to heal in a specified time leaves several options open. One could proceed with a longer course of therapy with the same agent, switch to an alternative agent or consider surgery. The exact course is not clear in all individuals. Our study was designed to answer the question as to whether or not an ulcer resistant to ranitidine at four weeks of therapy would respond to a full course of treatment with cimetidine.

We have shown that cimetidine therapy may be effective in duodenal ulcers that have been resistant at four weeks to a standard course of ranitidine therapy. All patients resistant to a four week course of ranitidine demonstrated endoscopic improvement on cimetidine. Following an inadequate response to ranitidine, a full course of cimetidine resulted in an overall endoscopic cure rate of 80% in 28 of the 35 patients. There was also an overall rate of symptomatic relief in 32 of the 35 patients (91%). Smoking appeared to have a slight deleterious effect on healing.

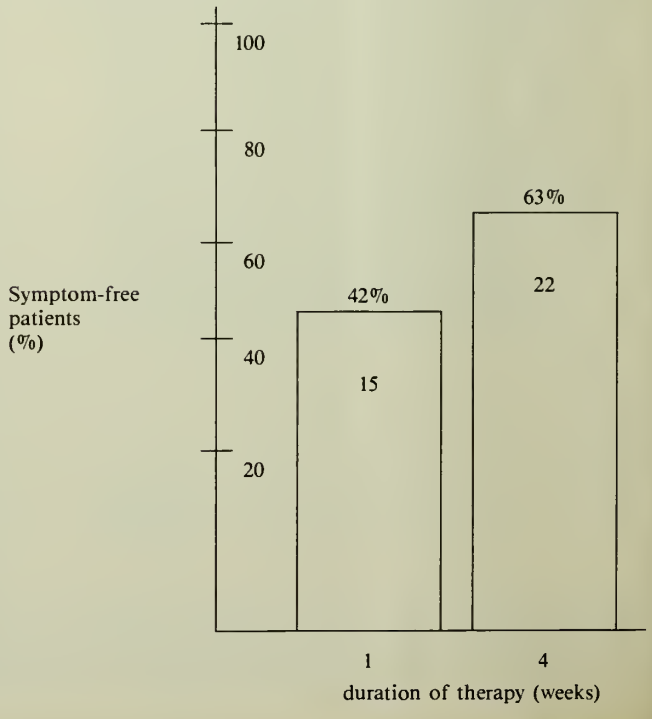
A multitude of factors have been advanced as potential reasons for ulcer refractoriness.[4-13] These include genetic factors, age, sex, smoking, alcohol consumption, occupation, emo-

Table II

Endoscopic Results of Ranitidine Therapy

Treatment	Patients entered (35)		Healed on Endoscopy (19)		
Ranitidine (150 mg bid for 4 weeks)	Smokers	15	Smokers	6	40%
	Non-smokers	20	Non-smokers	13	65%

Symptomatic Response to Ranitidine Therapy



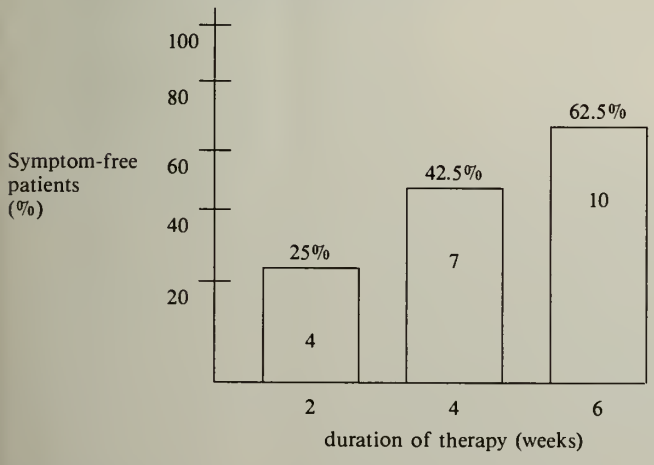
tional stress, the size and shape of the ulcer and pre-treatment levels of acid secretion. The rate of pepsin and the prominence of vagal drive have been investigated. Other possible causes for refractoriness include poor patient compliance, inadequate drug absorption, and insensitivity to H_2-receptor antagonist therapy. The role of inadequate mucosal defense mechanisms is receiving increasing attention. Bardhan was unable to detect significant clinical laboratory or endoscopic features that distinguished the refractory from the non-refractory ulcer patient.[4] Thus, the cause of refractoriness remains unknown.

It would seem that a prudent approach to the patient with a ranitidine resistant ulcer at four weeks of treatment, from our data and the data of others, would have to include either a longer course of treatment with ranitidine or a course of therapy with cimetidine prior to labeling these ulcers resistant to therapy and giving consideration to surgery.

Table III
Endoscopic Results of Cimetidine Therapy in Ranitidine Resistant Patients

Treatment	Patients entered (16)		Healed on Endoscopy (9)	
Cimetidine (300 mg qid for 4 weeks)	Smokers	9	Smokers	4
	Non-smokers	7	Non-smokers	5

Symptomatic Response to Cimetidine Therapy in Ranitidine Resistant Patients



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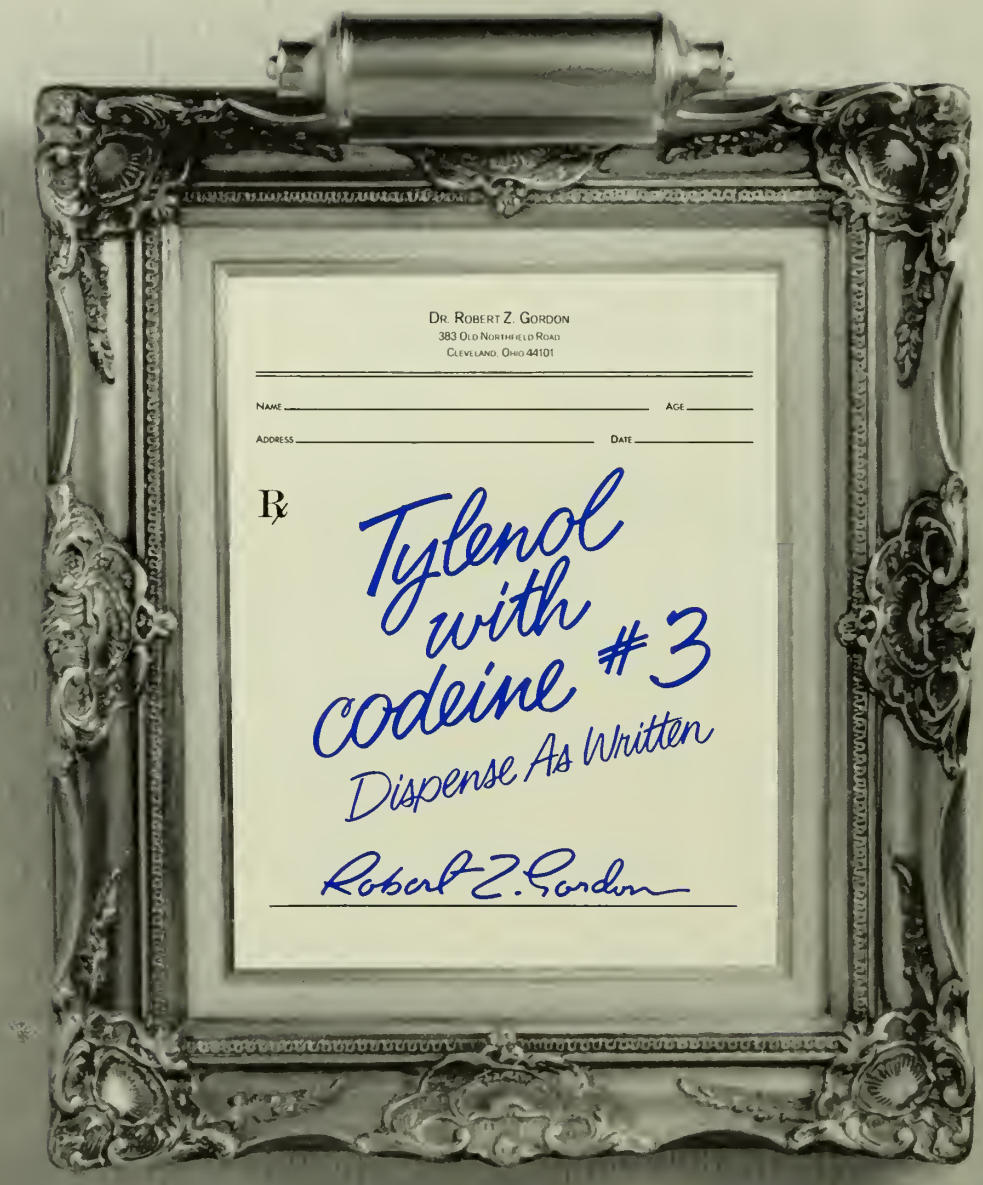
Physicians of the rich and famous

Can you imagine the likes of Elvis Presley, Howard Hughes, Pope John Paul II, or President Reagan sitting in your waiting room?

In *Extraordinary Care,* a new novel by Dennis Breo, special assignment editor of *American Medical News,* doctors of the rich and famous reveal medical and personal insights about a host of noteworthy patients.

The novel is a pastiche of AMN news features written by Breo, and also delves into big-controversy subjects such as laetrile, the mind of John Hinckley, Chappaquiddick, Baby Fae, and the artificial heart, among other things.

The story-behind-the-story accounts indicate that the ultra-famous can also be ultra-difficult patients. Wilbur Thain, MD, the physician who treated the reclusive billionaire Howard Hughes, gave this account: "By his own choice, Hughes never walked again. Once, with help, he walked from the bedroom to the bathroom. But only once . . . Hughes' approach was to promise you anything and never do it . . . I got so frustrated that I almost quit."



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CORRELATION BETWEEN PMS AND ALCOHOLISM AMONG WOMEN

William A. Price, MD
Lynn R. DiMarzio, MS
Jane Lehr Eckert, PhD

Fifty women alcoholics and 50 nonalcoholic women were asked to anonymously fill out Menstrual Symptomatology Questionnaires to ascertain the severity of premenstrual syndrome (PMS) symptoms. A significantly greater number of women alcoholics were found to suffer from severe PMS than their nonalcoholic counterparts. Women alcoholics have been previously reported to binge drink more frequently than men and drink more frequently to relieve anxiety and depression. PMS may contribute to the development of this anxiety and depression.

Alcoholism among women is a significant and growing problem. Although it was once thought of as a disease that predominantly affects men, the gap between the sexes now seems to be narrowing! Even so, the female alcoholic differs markedly from her male counterpart. The diagnosis of primary affective disorder may be made in a significant number of women but not in men.[2] Excessive drinking in women is more intimately associated with specific precipitating circumstances.[3] Women alcoholics also exhibited an exceptionally high degree of anxiety, the origin of which is unknown, and about which there is an inability to do anything.[4] Alcohol tended to be valued for its ability to relieve anxiety and to allow a woman to be the type of person she wanted to be.[5] Periodic drinking sprees have been known to occur with regularity in the presence of painful periodic illnesses that patients have learned to relieve with alcohol. Premenstrual syndrome (PMS), with its associated anxiety, depression, and irritability, can be one such periodic illness. Patients with a broad range of common psychiatric disorders complain of premenstrual worsening of symptoms, which include anxiety disorders, depression, mania, schizophrenia, and borderline personality disorder.[6] A possible relationship between PMS and alcoholism among women has been hypothesized but inadequately documented. Nonetheless, several researchers have reported that a subgroup of women alcoholics associate their drinking with their menstrual cycle.[7,8] This study was undertaken to evaluate and clarify the association between PMS and alcoholism among women.

William A. Price, MD, Director, PMS Program, Parkview Counseling Center (Youngstown) and clinical instructor in psychiatry, Northeastern Ohio Universities College of Medicine (NEUCOM), Rootstown; Lynn R. DiMarzio, MS, clinical research associate, NEUCOM; and Jane Lehr Eckert, PhD, staff psychologist, Ignatia Hall Alcohol Abuse Center (Akron), and clinical instructor in psychiatry, NEUCOM.

Methods

Fifty women (ages 21 to 42, mean age 31.5) who met DSM-III criteria for alcohol abuse participated in this study. All women at the time of the study were inpatients in a hospital-based alcohol detoxification and treatment program. Additionally, all women were still menstruating regularly. Women on oral contraceptives were excluded from the study. This accounted for only five women out of the possible 55 treated during the nine-month time period from June 30, 1985, to April 1, 1986. Women were asked to anonymously fill out the Abraham Menstrual Symptomatology Questionnaire (MSQ).[9] Participants in the study were informed that the questionnaire was part of an ongoing study, but they were not informed of the purpose of the study. No woman refused to fill out the questionnaire.

A control group of 50 women (ages 20 to 43, mean age 32.1) with similar educational and socioeconomic backgrounds was

obtained through the outpatient department of the same hospital. All women were still menstruating and none were using oral contraceptives. Women were randomly selected and asked to anonymously fill out the MSQ. Again, no woman refused.

The MSQ was developed by Abraham to assess four different groups of premenstrual symptoms: PMT-A (nervous tension, mood swings, irritability, and anxiety); PMT-H (weight gain, swelling of the extremities, breast tenderness, and abdominal bloating); PMT-C (headaches, craving for sweets, increased appetite, fatigue); and PMT-D (depression, forgetfulness, crying spells, confusion, and insomnia). On the basis of this questionnaire, the severity of PMS can be assessed quantitatively with a four-point scale in which zero is no symptoms, one is mild, two, moderate, and three, severe. Severity of PMS is judged as follows: mild: total score for A or H is less than five, less than six for D, and less than seven for C; moderate: five to eight for scales A or H, six to 10 for D, and seven to 12 for C; severe: nine to 12 for A or H, 11 to 15 for D, and 13 to 18 for C.

TABLE I
Comparison of PMS Severity in Alcoholic and Nonalcoholic Women

PMS Level	Alcoholic N=50	Nonalcoholic N=50	Row Total
Mild	14 (21.0)	28 (21.0)	42
Moderate	12 (13.0)	14 (13.0)	26
Severe	24 (16.0)	8 (16.0)	32
Column Total	50	50	100

$chi^2 = 12.82$, $p < .01$
Note: Expected frequencies in parenthesis

Results

Table I reflects the score distribution for the alcoholic group (50) and the nonalcoholic control group (n=50) according to the three PMS levels (mild, moderate, severe) measured by the MSQ. Twenty-four (48%) of the alcoholic women were categorized as experiencing severe PMS, compared to only eight (16%) women in the control group. With respect to the control group, the "mild" PMS category obtained the highest corresponding frequency (n=28; 56%), whereas there were only 14 women (28%) in the alcoholic group in that categorization.

A chi-squared analysis was performed on the categorical data. Acceptable confidence intervals were set at the alpha .05 level. The obtained and expected frequencies are illustrated in Table I. The results indicate that the alcoholic group was significantly different from the nonalcoholic group with respect to the severity of PMS ($chi^2 = 12.82$, (2) df, $p < .01$).

Discussion

The results indicate that a significantly greater number of women alcoholics suffer from severe premenstrual symptoms than their nonalcoholic counterparts. This finding has several implications. First of all, PMS may precipitate alcohol use in some women. Alcoholism and heavy drinking in women appear more likely to be linked to psychological stress and a specific precipitating cause than does alcoholism or heavy drinking in men.[10] Women alcoholics reported that they were most likely to drink when they were tense or nervous; they drank to relax or forget worries. Traditionally acceptable cultural reasons such as "to be sociable" or "I like the taste" appear to hold less importance to women alcoholics than men.[11] Women alcoholics also suffer more frequently with anxiety and affective disorders than do men.[2] The root of this anxiety and depression may be PMS. Interestingly enough, women are more likely to be periodic or binge drinkers, while men are more likely to be continuous drinkers[12]. Belfer et al.[8] have linked this binging to the menstrual cycle, finding that 67% of menstruating women relate the onset of their drinking episodes to tension during the premenstrual phase. If women do, in fact, self-medicate themselves with alcohol in an attempt to decrease their PMS-related anxiety, irritability, and depression, then treating their PMS first with one of the numerous acceptable treatments may make the rehabilitation process easier. Certainly more research is needed to help elucidate the full effect the menstrual cycle and PMS may have upon the development of alcoholism in women.

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Next month in Ohio Medicine:

The 1987 Annual Meeting program issue

Let "The Spirit of Caring" carry you to this year's Annual Meeting, to be held May 15, 16, and 17 in Columbus. Look for your hotel reservation forms in the OSMAgram and details of the meeting in next month's issue.

Continuing Medical Education Calendar



March

LUNG CANCER CONFERENCE: March 6; Hyatt on Capitol Square, Columbus; sponsor: Riverside Methodist Hospital; 5½ credit hours, category 1; fee: $75, $40 others; contact: Angie Leonard, Riverside Methodist Hospital, 3535 Olentangy River Rd., Columbus 43214; phone: 614/261-4475.

April

FOURTH RICHARD W. VILTER CANCER SYMPOSIUM, BIOLOGICAL RESPONSE MODIFIERS IN CANCER: April 9; Westin Hotel, Cincinnati; sponsor: Univ. Cincinnati College of Medicine; jointsponsor: American Cancer Society; 6 credit hours, category 1; fee: $50, $25 others; contact: Orlando J. Martelo, MD, Director, Hematology-Oncology Division, 6367 Univ. Cincinnati College of Medicine, 231 Bethesda Ave., M.L. #562, Cincinnati 45267; phone: 513/872-4233.

ANNUAL NICHOLAS J. THOMPSON CANCER UPDATE: UROLOGIC CANCERS: April 22; Dayton Marriott Hotel, Dayton; sponsor: Wright State Univ. School of Medicine; jointsponsor: The David L. Rike Comm. Cancer Center at Miami Valley Hospital and Ledlerle Lab; 7 credit hours, category 1; no fee; contact: Cheryl Little, Arrangements Coordinator, WSUSOM, P.O. Box 927, Dayton 45401-0927; phone: 513/429-3200, X5407.



May

OHIO CHAPTER, AMERICAN COLLEGE OF SURGEONS, ANNUAL MEETING: May 1-2; Dayton Marriott Hotel; sponsor: American College of Surgeons; 15 credit hours; fee: $100/members; $150/non-members; $25/residents; contact: Robert P. Turk, M.D., Program Chairman, 601 Edwin C. Moses Boulevard, Dayton, Ohio 45408, phone: 513/229-6627.

REVISED REFRESHER COURSE IN DIAGNOSTIC ROENTGENOLOGY: May 4-8; Clarion Hotel, Cincinnati; sponsor: University of Cincinnati College of Medicine; 34 credit hours, category 1; fee: $350; contact: Dr. Harold B. Spitz, Department of Radiology, University Hospital, 234 Goodman Street, Mail Location 742, Cincinnati 45267; phone: 513/872-7226.

THE 8TH ANNUAL ENDOCRINE/METABOLIC SYMPOSIUM FOR HEALTH PROFESSIONALS: May 14; Hotel Sofitel, Toledo; sponsor: Department of Endocrinology of Mercy Hospital; jointsponsor: Medical College of Ohio; 7 credit hours, category 1; fee: $50; contact: Suzanne V. Girkins, Coordinator, Mercy Hospital Endocrine and Diabetes Care Center, 2238 Jefferson Ave., Toledo 43524; phone: 419/259-1370.

Letters to the Editor . . .

continued from page 133

interested in getting patients out of bed after surgery immediately and was dissuaded by his peers. He then devised a variant of a bicycle to be used in bed to avoid the complications of thrombophlebitis and pulmonary emboli. The same for obstetrical patients who used to be in the hospital for a week and now go home the following day. I could go on about the changes in medical care. The important thing is that reducing hospital stay and cutting back unnecessary or duplicate ancillary services may not necessarily reduce quality of care. Physicians should order the necessary and appropriate testing to determine the reason for the illness and the appropriate treatment for the specific problem at hand. We are still faced with the not uncommon sequencing of a patient being worked up for an abdominal problem and having a CT scan of the abdomen, liver spleen scan and ultrasound of the upper abdomen. It is apparent that all of these tests are not necessary, and are expensive and redundant.

The change of the system from the previous method of reimbursement under the Medicare system to the Prospective Payment System has led to a decrease in admissions, length of stay and use of ancillary services. What has not been shown is that these changes have resulted in poor patient care and increase in complications. Nowhere in the federal regulations is it required that the physician discharge a patient when not ready. We should not be forced into premature discharge of our patients. However, we should work with our peers of the UR Committees to develop a consensus for the appropriate length of stay for a given patient.

I am Medical Director of Medco Peer Review, Inc., in Cincinnati, a PRO organization and a

continued on page 204

OBITUARIES

EDWARD ARBAUGH, JR., MD, St. Clairsville, OH; University of Cincinnati College of Medicine, 1930; age 81; died November 22, 1986; member OSMA and AMA.

F. PAUL BAURICHTER, MD, Cincinnati; University of Cincinnati College of Medicine, 1934; age 79; died January 3, 1987; member OSMA and AMA.

JOHN F. BUCK, MD, Tipp City; Northwestern University Medical School, Chicago, Illinois, 1927; age 84; died December 15, 1986; member AMA.

CHARLES O. BUTNER, MD, Shiloh; University of Arkansas School of Medicine, Little Rock, Arkansas, 1934; age 76; died December 12, 1986; member OSMA and AMA.

DAVID G. DILLAHUNT, MD, Columbus; Ohio State University College of Medicine, 1937; age 74; died January 13, 1987; member OSMA and AMA.

ROBERT GILL, MD, Columbus; Ohio State University College of Medicine, 1962; age 49; died December 7, 1986; member OSMA.

EVELYN LAVERY, MD, Akron; Ohio State University College of Medicine, 1952; age 69; died December 12, 1986; member OSMA and AMA.

STEPHEN MOEHLMAN, MD, Sidney; Tulane University School of Medicine, New Orleans, Louisiana, 1967; died August 31, 1986; member OSMA.

CHARLES McMULLEN, MD, Loudonville; Ohio State University College of Medicine, 1950; age 63; died December 30, 1986; member OSMA and AMA.

HECTOR SIAT, MD, Grafton; Faculty of Medicine & Surgery, University of Santo Tomas, Manila, Philippines, 1952; age 61; died December 21, 1986; member OSMA.

JAMES TOLAND, MD, Cambridge; University of Cincinnati College of Medicine, 1934; age 78; died December 28, 1986; member OSMA and AMA.

We're Looking for Contributors . . .

This year, why not become a contributor as well as a reader of *Ohio Medicine*? We can always use "Second Opinion" and "Letters to the Editor."

Letters to the Editor

continued

subcontractor to Peer Review Systems, Inc., of Columbus, Ohio, the primary contractor PRO in Ohio. I am a general surgeon in active practice.

Sincerely,
Harold Pescovitz, MD
Cincinnati

Correction

The January 1987 issue of *Ohio Medicine* mistakenly identified Richard Martin Friedmar, PhD, as Richard Martin Friedman in a Medi-scene story which appeared on page 16. The *Ohio Medicine* staff regrets the error.

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Boarded or Board Eligible family practitioners are needed to meet our patient population growth in 1987. Our multi-specialty group practice offers an excellent salary and fringe package and a good group of residency trained, boarded Family Practitioners with whom to work. C.V.s to Search Committee, Group Health Associates, 2915 Clifton Avenue, Cincinnati, Ohio 45220.

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FAMILY PRACTICE PHYSICIAN wanted to work with three other family practice physicians in a 21 physician multispecialty group practice clinic in a 20,000 population college town in North Central Ohio. Reply to Ohio Medicine, 600 S. High Street, P.O. Box 122, Columbus, Ohio 43215.

HOUSE PHYSICIANS: Full-time and part-time Medical/Surgical and OB/GYN House Physician positions available in July, Ohio license required. Prefer board eligible/board certified physician. Hospital is a community teaching hospital. Attractive salary and benefits. Contact Barberton Citizens Hospital, c/o House Physician Recruitment, Tuscora Park, Barberton, Ohio 44203. EQUAL OPPORTUNITY EMPLOYER. m/f/h.

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OBERLIN, OHIO 21 person multispecialty group seeks additional BC/BE family physicians, internist, cardiologist, and otolaryngologist. North central Ohio college town serving drawing area of 290,000. Salaried position first year; full shareholder status available in second year. Send CV to Dr. VanDyke, 224 W. Lorain, Oberlin, OH 44074.

OBSTETRICIAN/GYNECOLOGIST (BC/BE). Immediate opening to join an established and growing two-man practice in South Central Ohio. Experience in Ultrasound, Infertility, and Microsurgery desired. Excellent professional and recreational opportunity. Modern 225-bed hospital serving pop. of 60,000+. Send CV to: Center OB-GYN Associates, Inc., PO Box 969, Station A, Chillicothe, OH 45601, 614/773-1133.

OHIO: Emergency Medicine positions ranging from part-time placements to full-time Directorships. Low to high volume hospitals throughout the state. Guaranteed hourly rate plus malpractice insurance. Contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 26, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

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OHIO PHYSICIAN OPPORTUNITIES — Board certified/eligible family practice, general surgeon and orthopedic surgeon needed in south-central Ohio. Easy access to Columbus, Dayton and Cincinnati. 50,000 population trade area with 70-bed hospital. Some opportunities to join existing practice. Excellent schools/family community/many recreational opportunities. Competitive compensation package. Contact: H. James Graham, Fayette County Memorial Hospital, 1430 Columbus Ave., Washington Court House, OH 43160 — (614) 335-1210.

PEDIATRICIAN. Solo practice available immediately. SE Ohio, City 35000. Accredited hospital, 1 hour from any place in Columbus. Gross $225,000+. Practice free to pediatrician who will rent fully equipped office. Will introduce. Respond to Box 126, c/o Ohio Medicine, 600 S. High Street, Columbus, Ohio 43215 with curriculum vitae.

PHYSICIANS: Fast growing group practice in Northeastern Ohio has opening for two physicians, Board Certified or Board Eligible, with an interest in General Internal Medicine and Preventive Medicine. Some Cardiology involved. Excellent practice facility, guaranteed first year salary, excellent benefits. Interested applicants reply to PO Box 123 c/o Ohio Medicine, 600 S. High St., Columbus, Ohio 43215.

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PHYSICIAN WANTED to join busy, established family practitioner in a lovely college town in Central Ohio. Obstetrics optional. This is a satellite operation of a well-established multispecialty group practice just 18 miles distant. Shareholder status in the parent group available after the first year. Very competitive starting salary with superb fringe benefits. Please reply to PO Box 95, c/o Ohio Medicine, 600 S. High Street, Columbus, OH 43215.

PRIMARY CARE PHYSICIANS. Multi-state practice association seeks BE/BC primary care physicians for unique opportunities in Pa., N.J., New England, Md., Fla., and other areas of the US. Most positions offer Monday-Friday 8 am to 5 pm schedules with up to *five* weeks paid time off. Paid malpractice. Contact or send CV to Liberty Healthcare Corporation, 399 Market Street, Suite 400, Philadelphia, PA 19106, (215) 592-7400 or outside Pa. (800) 331-7122.

PSYCHIATRISTS. Immediate openings for Staff Psychiatrists, full time and part time, board eligible/board certified, in a state-operated, JCAH accredited, 380-bed inpatient psychiatric hospital. Multidiscipline approach with psychiatrist as a treatment team leader, expected to exercise strong leadership in quality care of patients. Programs for acute admissions, extended care, geriatrics and psychiatric rehabilitation. License to practice in the state of Ohio is required. We are located about 20 miles from Akron, population: 300,000; excellent school system and outdoor activities. Massillon and adjacent Canton has a combined population of 110,000. Salary starts at $54,308 annually, with expected increase to $57,034 on 1/1/87. Excellent fringe benefits including paid vacation and personal leave, sick and educational leave, health, vision, dental and life insurance, etc.

Travel costs may be negotiated. Faculty appointment to the Northeastern Ohio University College of Medicine possible for qualified applicants. EEO Employer, M/F/H.

Send resume to W.J. Roberts, Director of Personnel, Massillon State Hospital, Box 540, Massillon, OH 44648, or call (216) 833-3135, ext. 223.

URGENT CARE CENTER PHYSICIANS

Cleveland, Ohio. Urgent Care Center Physicians. Our caseload is up. Our group owns and operates four (4) urgent care centers in the western suburbs of Cleveland. We offer the opportunity to practice medicine in a pleasant, supportive atmosphere with top-notch staff. We are one of the most successful groups of urgent care centers in Ohio. We attribute our success to the fact that they are owned and operated by physicians who strive to provide quality medical care to our patients.

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Attorney Ralph Higgins
Westview Towers
21010 Center Ridge Rd.
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MEDICAL PRACTICE FOR SALE: MD practitioner retiring. Southeastern Ohio university town. Ideal for solo Family Practitioner or Internist. Reply to PO Box 112, c/o Ohio Medicine, 600 South High Street, Columbus, OH 43215.

Position Wanted

POSITION DESIRED. 58 years of B.E. OB-Gyn, Licensed in Ohio. Looking for a position in any institution. Phone area code 614-353-1553 or 614-858-6213.

POSITION WANTED: BOARD CERTIFIED CARDIOLOGIST (internist) Invasive-Non Invasive, Ohio licensed, wishes to join group, hospital, industry, company, etc. Reply to Box 125, c/o Ohio Medicine, 600 S. High Street, Columbus, OH 43215.

Seminars

OCCUPATIONAL MEDICINE TRAINING

Mini-Residency beginning June 8-19, 1987 and continuing October 12-16, 1987 and March 14-18, 1988. Clinical & Administrative Occupational Medicine, Epidemiology & Biostatistics, Industrial Hygiene, Toxicology, Regulations, etc. 111 AMA Cat I, AAFP prescribed, Cat 2-D AOA and Cat I ACEP credits. 11th year. References from past participants provided. $650 per week. Sidney Lerner, MD, College of Medicine, Mail Location 182, Cincinnati, Ohio 45267-0182, 513-872-4043.

GREAT LAKES ASS'N OF CLINICAL MEDICINE PRESENTS: ***TRUE PREVENTIVE MEDICINE.*** "Nutrition Is Therapy": Jonathan Wright, MD, of Wright/Gaby Foundation, March 26-27 (1½ days). "Elemental Medicine": International Congress with noted speakers, March 27-28 (1½ days). Contact Warren Delano, 24700 Center Ridge Road, Westlake, OH 44145. (216) 835-1212.

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COLLEAGUES IN THE NEWS

Charles Barrett, MD, Cincinnati, will be honored with a Great Living Cincinnatian Award at the Greater Cincinnati Chamber of Commerce annual meeting.

G. Robert Barton, MD, a Youngstown general practitioner, has been elected president of the Mahoning County Medical Society.

Theodore J. Castele, MD, a Cleveland radiologist, has received the "Man of the Year" Award from the Lutheran Medical Center Foundation.

John R. Donohoo, MD, has been named the 1986 "Outstanding Citizen of the Year" by the Georgetown Area Chamber of Commerce.

Glenn E. East, MD, associate director of the Family Practice Center at Aultman Hospital in Akron; **James D. Johns, MD,** a Canton private practitioner and team physician for McKinley Senior High School; and **George DeSilvester, MD,** a third-year family practice resident at Aultman, have been appointed to a statewide Sports Medicine Committee organized by the Ohio Academy of Family Physicians.

George Esham, MD, Portsmouth, has been elected president of the Scioto County Medical Society.

Thomas J. Fischer, MD, Cincinnati, has been installed as chairman of the Section on Allergy and Immunology of the American Academy of Pediatrics. Dr. Fischer, an allergist with Group Health Associates, is the president of the Ohio Society of Allergy and Immunology.

Gary L. Gillen, MD, a Circleville family practitioner, has received the American Red Cross chairman's award for his "service and leadership as chairman of the Central Ohio American Red Cross Blood Services Committee."

B. Leslie Huffman, Jr., MD, Maumee, has been elected 1986-87 president of the American Board of Medical Specialties.

Christopher M. King, MD, an Alliance ophthalmologist, has been installed as the 1987 president of the Stark County Medical Society.

Ben Madow, MD, a Cleveland internist, has been awarded the Suburban Community Hospital's "Physician of the Year Award."

Charles McClelland, MD, Beachwood, clinical professor of pediatrics at Case Western Reserve University School of Medicine and head of the pediatric clinical faculty, has received the first Golden Microscope Award for excellence in teaching and patient care.

William A. Moore, MD, Russellville, recently received the "Dr. Vytautas Karoblis Commemorative Award for Meritorious Service" from Brown County General Hospital.

Grant Morrow III, MD, Columbus, chief of pediatrics at Columbus Children's Hospital, has been elected to serve on the American Board of Pediatrics.

Donald A. Novak, MD, Cincinnati, a third-year research fellow at Children's Hospital Medical Center, has been awarded the 1986 Drew Fox Memorial Postdoctoral Research Fellowship by the American Liver Foundation.

Richard C. Orahood, MD, a general surgeon from Delaware, has been elected president of the American Cancer Society Ohio Division at the society's annual meeting.

Richard D. Ruppert, MD, Toledo, president of the Medical College of Ohio, has been re-elected as a member of the Board of Trustees of the American Society of Internal Medicine.

William K. Schubert, MD, president of Children's Hospital Medical Center in Cincinnati, has been appointed chairman of the Board of the Ohio Solid Transplant Consortium.

Melvin Shafron, MD, has been elected vice president, and **O. David Solomon, MD,** secretary-treasurer, of the Cleveland Academy of Medicine.

Richard B. Simpson, MD, a Northup pediatrician, has been chosen to serve as the Ohio coordinator for a nationwide research project being conducted by American Academy of Pediatrics.

Marvin Sobel, MD, Cleveland, recently received the Mortimer Siegel, MD, Award at the Mt. Sinai Medical Center Annual House Reception for "his distinguished achievement as an attending medical clinician."

Alan J. Sogg, MD, a physician at the Community Hospital of Bedford, was recently recognized at the American Academy of Otolaryngology Annual Meeting with an Honor Award for contributions to his field.

Robert T. Stone, MD, director of Gastroenterology and immediate past-president of Children's Hospital in Akron, has been awarded the 1986 Doug Dieken Award for Courage.

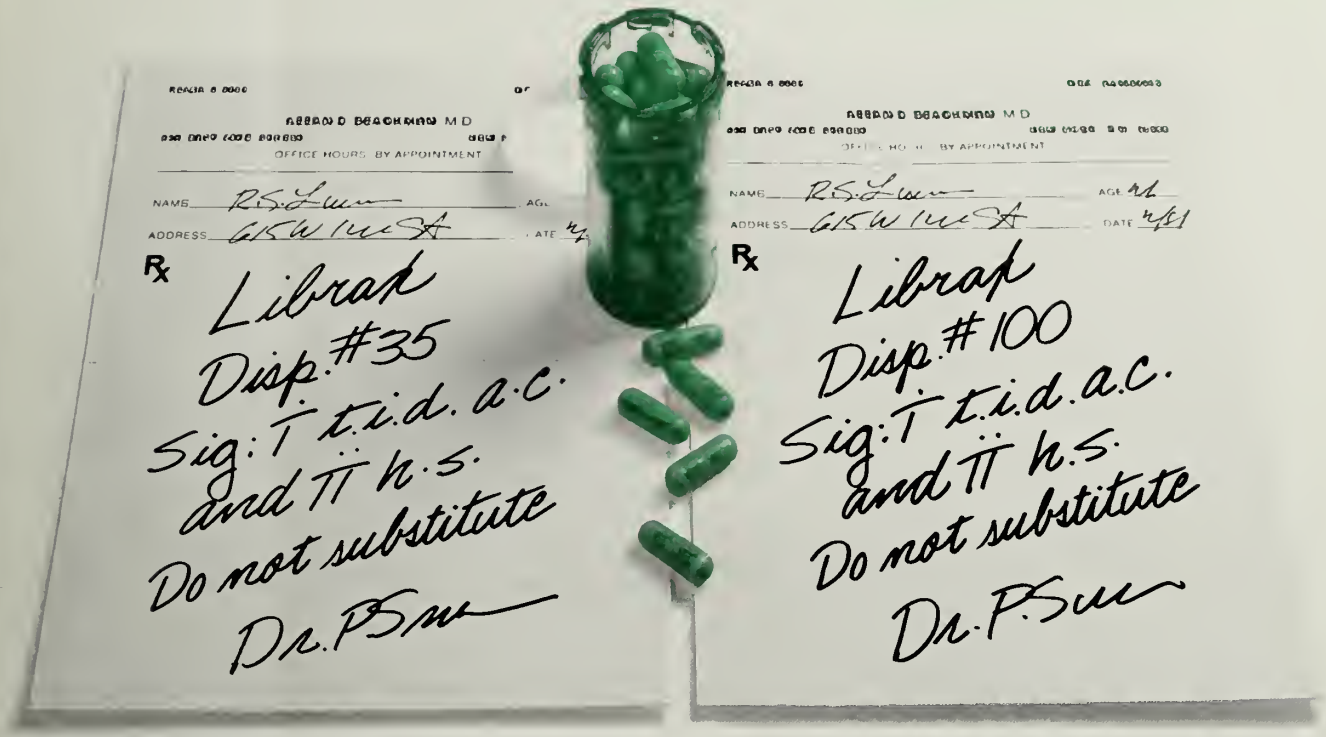
Daniel L. Storer, MD, Cincinnati, has been elected president-elect of the Ohio Chapter of the American College of Emergency Physicians.

James I. Tennenbaum, MD, a Columbus allergist, has been elected first vice-president of the American Association for Clinical Immunology and Allergy and reappointed associate editor of the association's official journal. Dr. Tennenbaum has also been elected to the Board of Directors of the Asthma and Allergy Foundation of America.

Robert E. Tschantz, MD, a Canton internist, recently received the Paul Harris Fellow Award from the Canton Rotary Club.

Paul G. Zerbi, MD, a Warren thoracic and cardiovascular surgeon, has been installed as the 1987 president of the Trumbull County Medical Society.

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Final classification of the less-than-effective indications requires further investigation.

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As with all anticholinergics, inhibition of lactation may occur.

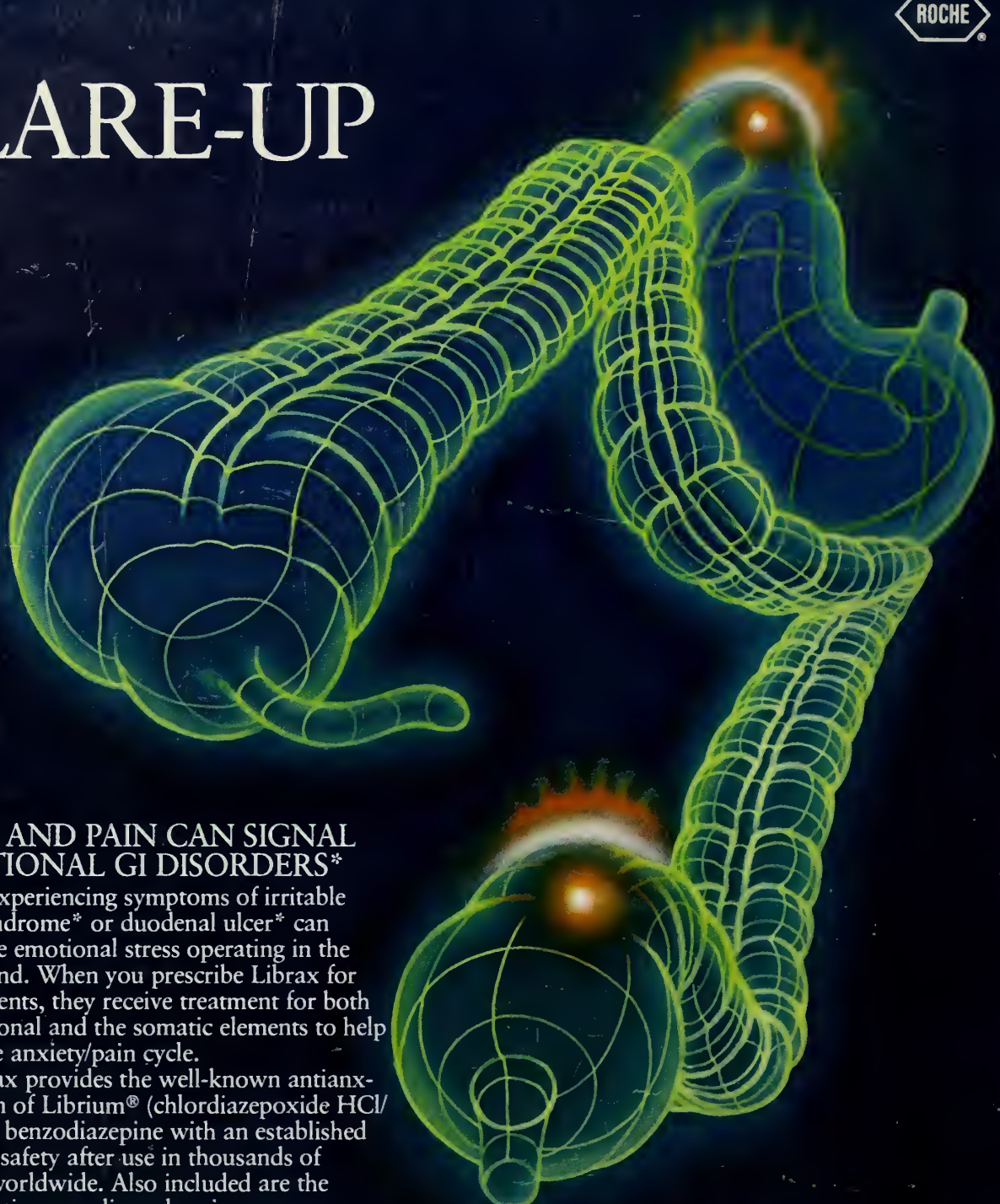
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

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OHIO Medicine

JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

VOL. 83, NO. 4 APRIL 1987

DISPLAY SHELVES



1987 OSMA ANNUAL MEETING



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References: **1.** Kales J, *et al Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971 **2.** Kales A, *et al. Clin Pharmacol Ther 18* 356-363, Sep 1975 **3.** Kales A, *et al. Clin Pharmacol Ther 19* 576-583, May 1976 **4.** Kales A, *et al Clin Pharmacol Ther 32* 781-788, Dec 1982 **5.** Frost JD Jr, DeLucchi MR. *J Am Geriatr Soc 27* 541-546, Dec 1979 **6.** Dement WC, *et al Behav Med*, pp. 25-31, Oct 1978 **7.** Kales A, Kales JD. *J Clin Psychopharmacol 3* 140-150, Apr 1983 **8.** Tennant FS, *et al* Sympasium on the Treatment of Sleep Disorders, Telecanference, Oct 16, 1984 **9.** Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther 21* 355-361, Mar 1977

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FROM THE EDITOR

A Spirit of Caring

This month, of course, *Ohio Medicine* presents its annual program issue, highlighting the schedule and events that will take place as delegates from around the state convene in Columbus May 15-18 for this year's OSMA Annual Meeting.

The theme of this year's meeting, "The Spirit of Caring," carries a thoughtful message, not only to the medical community itself, but to the public at large. The concern of doctors for the care and well-being of their patients is a tradition that dates back to Hippocrates — yet in this age where corners are being haphazardly clipped in efforts to lower health care costs, it's good to see that the medical profession has not lost sight of its traditional raison-d'être — its reason for being. And, once in a while, it's good to remind ourselves, as well as those around us, just *who* it is that's doing the caring.

As you flip through this issue, don't forget that *this* annual meeting is "business only." The clinical and scientific programs (which usually follow the weekend business meeting) will have their own special meeting dates this year — September 18-20. Be watching *Ohio Medicine* for further details of this special clinical section (August will serve as the program issue).

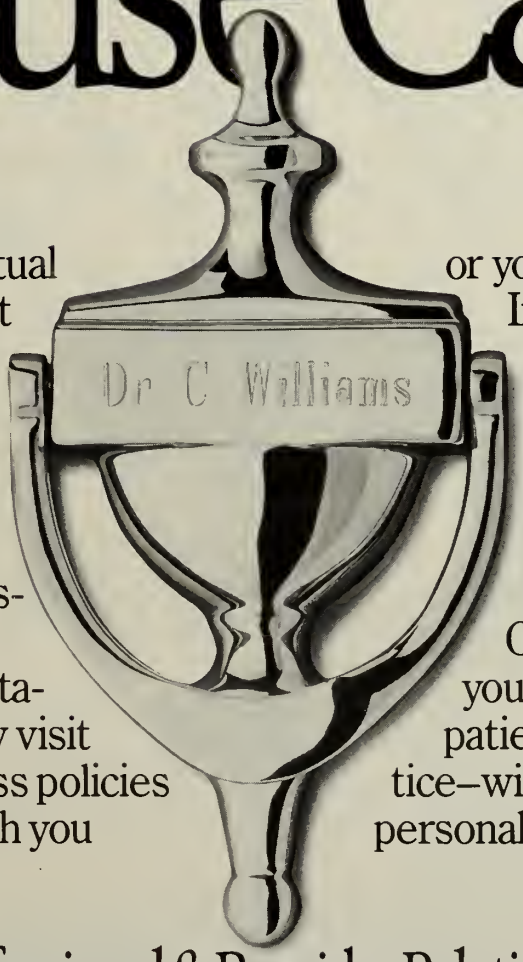
And speaking clinically — Associate Editor Susan Porter has prepared an updated report on AIDS in Ohio. We decided to do an update for two reasons — first, the last time we fully covered the subject was in our October, 1985 issue, and of course, much has happened in those two years. Second, the Ohio Department of Health is planning an AIDS Awareness Week next month in an attempt to prevent further growth of the disease through public education. A write-up of the ODH program is featured in this month's Ohio Medi-scene, along with an article on the activities of the OSMA Task Force on AIDS Discrimination. OSMA's Director of State Legislation, John Van Doorn, has also contributed a story to this section on his experience in Montgomery County's mini-internship program.

Art and Culture committee member James G. Ravin, MD, has contributed a fascinating article on noted author and lecturer Oscar Wilde. The article is every bit as entertaining as Dr. Ravin's other contributions on such noted authors and Ohio visitors as Arthur Conan Doyle and Charles Dickens — don't miss it!

Next month, *Ohio Medicine* will take a look at how Ohio is caring for its poor and elderly patients — a timely and pertinent topic, we feel, for an issue that will coincide with the OSMA's Annual Meeting and its "spirit of caring" theme. See you in Columbus!

Karen S. Edwards

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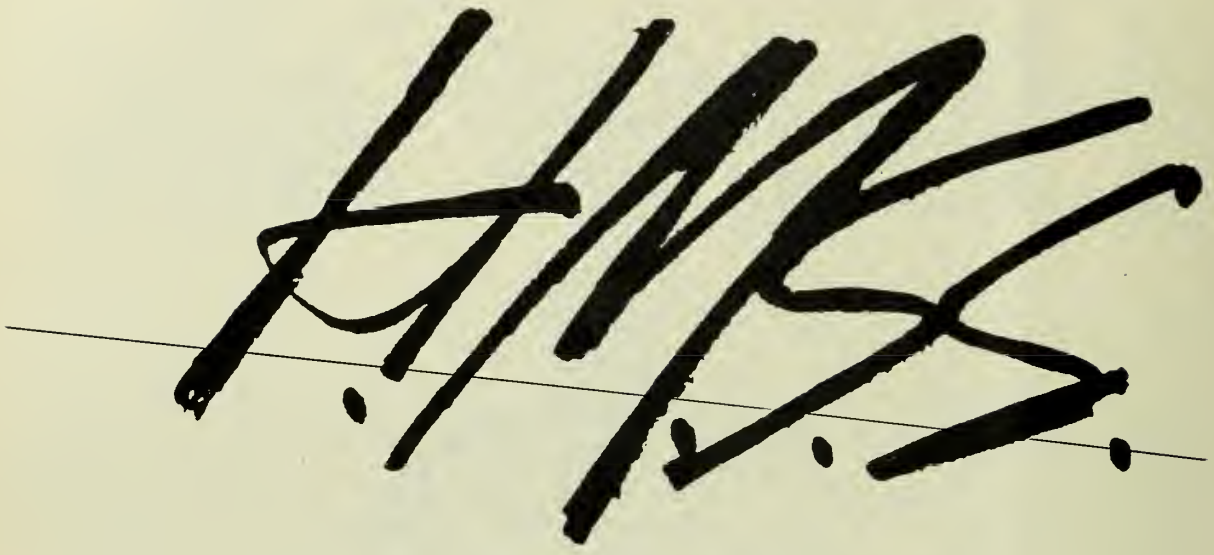
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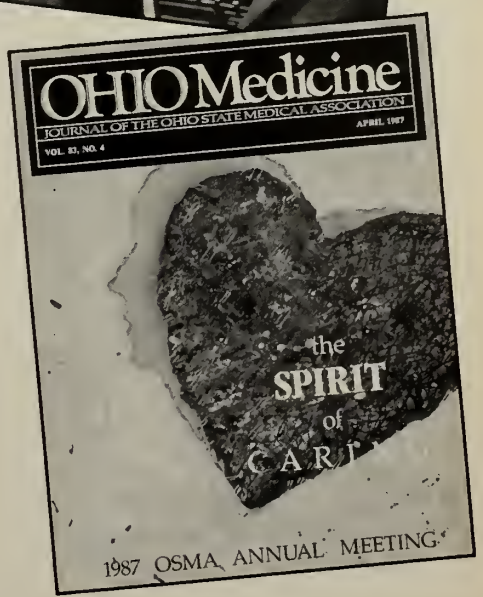
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House Bill 327/ Senate Bill 125

Remember those numbers, for in the next few weeks these bills, as identified as H.B. 327/S.B. 125, are going to be two of the hottest items in this state legislative session.

H.B. 327, as introduced by State Representative Paul Jones (D-Ravenna), and S.B. 125, as introduced by Senator David Hobson (R-Springfield), are identical bills which reform state laws regarding medical professional liability. The Council of the OSMA is confident that this legislation will help ease the growing problems associated with medical liability litigations. We are all aware of the increased cost of professional liability insurance and that one of every two physicians is almost certain of being involved in an alleged malpractice action, and the effects that this has on the way medical care is delivered in Ohio.

Physicians are forced to practice "defensive medicine" and it is estimated that this may add from $15 to $40 billion dollars annually to the nation's health care bill. From this standpoint only, something must be done to curb these expenditures and permit physicians to practice quality medical care without the threats of litigation.

Our patients also may be denied access to quality medical care as physicians in more and more areas are deciding to abandon higher risk procedures and specialties in order to reduce their chances of being involved in litigation. In the years 1981-1985, total payments by insurance companies to cover claims against Ohio physicians increased 46% annually as compared to 23% nationwide. At the same time, claims filed against Ohio physicians increased 13% annually.

The OSMA has a three-pronged approach to solve the liability problem. The first has already been enacted with legislation strengthening the Ohio State Medical Board. The medical profession must do everything possible to protect the public from physicians who do not meet the profession's standards.

The second and third prongs are both insurance and tort reform. H.B. I, which is now being considered, addresses general insurance and tort reform, and H.B. 327/S.B. 125 address medical liability tort reform.

H.B. 327/S.B. 125 in abstract seek these provisions:

1) more exact statute of limitations
2) periodic payments of damages
3) collateral source rule —other sources of compensation to be considered when setting the amount of the award
4) frivolous lawsuits — filing of suits to be accompanied by statements from physicians or dentists verifying justification of the suit with the right to recover costs from the plaintiff if the suit is dismissed on grounds of bad faith
5) economic vs. non-economic cost — clarifies what is economic and non-economic costs (Ohio already has a $200,000 cap on non-economic damages; non-economic — pain and suffering, etc.)
6) joint and several liability
7) arbitration panel — voluntary and binding when all parties agree to arbitrate
8) limitation on attorney contingency fees
9) a Study Commission to be established to evaluate the impact of H.B. 327/S.B. 125.

Recently you received a letter over my signature asking for voluntary contributions of $100 or more to be used in the efforts to have this legislation passed. These contributions are vital to our success for we have laid down the gauntlet, now let's support what invariably follows. Also, I urge you to contact your State Representative and Senator and express support for medical professional liability reform legislation.

Everyone has been waiting for the OSMA to do something about professional liability — WE HAVE DONE IT! WHAT ABOUT YOU? Let us know by your support in contributions that you are not just a tinkling symbol in the desert. **OSMA**

John E. Albers, MD
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Get In The Spirit
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BOSTON, MA
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Retired Doctors: A Prospective Role

Monitoring U.S. Health Care Reimbursement

By Leonard B. Greentree, MD

Now more than ever before, retired American doctors should play a dynamic role in monitoring Medicare and Medicaid reimbursement in the United States. Presently, greedy providers of these health care services go to great lengths attempting to become exceedingly wealthy in only a few years. It is important for the general public to keep well in mind that most American physicians have earned the right to be highly respected, and greedy members of our learned profession should not be permitted to cloud that well-earned right.

The authoritative *Medical Benefits* (September 30, 1985) medico-economic digest puts the problem at hand into proper perspective by citing cataract operations as an example of uncalled-for surgery making unscrupulous doctors very rich. Cataract surgery is the most frequently reimbursed surgical procedure in the United States. It has been estimated that 1.2 million people had this surgery during 1985. The cost of cataract surgery is expected to exceed $3.5 billion, of which Medicare will pay $3.03 billion, according to a report released by a House Subcommittee on Long-Term Care. Health and medical experts estimate that 23% to 36% of these cataract procedures may be unnecessary!

Presently, there is an inexcusable waste of retired physician mind-power in observing them idling their time playing cards and golf, consulting their stockbrokers, and watching endless TV on a daily basis in a vacation environment. Instead, assuming health care tasks preventing further abuse in physicians would be much more meaningful and exciting to them in the long run. Retired physicians should consider these roles in the same context as Peace Corps volunteers receiving a token salary for their much needed physical and mental effort.

It should be noted that a medical colleague and myself are elderly, former retired physicians now actively employed as medical technical advisors (MTA) by the Ohio Department of Human Services (ODHS) on Medicaid problems. In that role, we authorize payment to providers of designated tests, procedures and operations according to ever-changing guidelines established by the ODHS and the federal government. This particular MTA post has proved to be so mind-stimulating, I found myself at the State of Ohio Office Tower last July 4, working on my own time making decisions on financial reimbursement to doctors participating in the Ohio Medicaid program. It should be noted that my home life is still most important to me. This includes the dogs, the children, and my wife, not necessarily in that order. Although my medical colleague is also over 75 years of age, she has proved to be an alert, youthful individual effectively resolving complex Medicaid matters part time throughout the month.

As a Medical Technical Advisor for the Ohio Medicaid program at the state level, my recent recommendations on this topic include the following: Since cataract procedures are seldom an emergency, and since the profit motive is the only reason for far too many eye doctors in this situation, it was proposed that Medicaid deny payment of cataract operations without a second opinion. Unquestionably, this would greatly diminish unnecessary cataract procedures under the fiscal jurisdiction of the state of Ohio. It was also stressed that cataract surgery should be reserved for patients whose useful life can be improved!

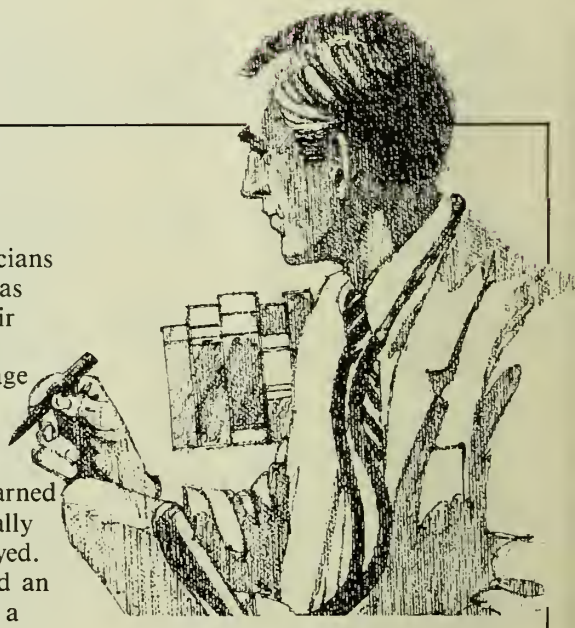
It is predicted that more and more retired doctors will assume a role of monitoring health care reimbursement and this task unquestionably will be a constant challenge to them! **OSMA**

Leonard B. Greentree, MD, is a retired physician living in Columbus.

OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians.

Physician employment trends



Just under half of all women physicians and younger physicians (excluding residents) were employees in 1985, according to a study by the AMA's Center for Health Policy Research. The study also indicated that the overall percentage of employee physicians (not counting those employed by the federal government or any resident physicians) increased from 23.4% to 25.7% from 1983 to 1985.

This statistically significant increase is believed to reflect the expanding role of alternative delivery systems in patient care and also the increasing competitive pressures confronting traditional self-employed physicians.

The study also found:

- 45.4% of all women physicians were employed in 1985 — as compared to 23.5% of their male counterparts;
- 47% of physicians under age 36 were employed, as compared to 19.5% of those over 55;
- Self-employed physicians earned nearly $38,000 more annually than those who are employed. The latter, however, worked an average of one to one and a half weeks less each year and devoted four less hours each week to practice-related activities.
- The lowest percentage of employed-physicians occurred among obstetrician-gynecologists (13.4%) and the surgical specialties (13.9%). The highest percentage of employed physicians (52.2%) was in the specialty of pathology.

What's in a dream?

Individuals who have frequent nightmares have particular personality and psychological traits that differ from those of other dreamers, according to an article in the *Archives of General Psychiatry.*

In a study of 12 lifelong nightmare sufferers, 12 vivid dreamers who had no nightmares, and 12 individuals who had neither vivid dreams nor nightmares, researchers found nightmare sufferers consistently scored higher on the "psychotic" portion of the Minnesota Multiphasic Personality Inventory profile, and had more close relatives with psychological problems.

The study also reported that nightmare sufferers were often sensitive and "open" people, some of whom had features of "schizophrenic spectrum disorders," but who also tended to have creative and artistic interests.



Crackdown on cancer

By the year 2000 the National Cancer Institute wants to cut the number of annual cancer deaths in half (an estimated 462,000 Americans died of cancer in 1985).

To pare down this figure, the institute plans for stepped-up efforts against cigarette smoking and a greater emphasis on diet, cancer prevention, screening, early detection and treatment.

Other strategies:

- To reduce the amount of fat in diets to less than 30% of total calories.
- To increase from 15% to 80% the number of women age 50 to 70 who undergo breast exams and X-ray mammography.
- To increase the percentage of women age 20 to 39 who have pap smears every three years.

Edited by Deborah Athy

Barefoot revival

During China's Cultural Revolution, villagers with little formal medical education — dubbed "barefoot doctors" — went on the road to encourage people to seek medical care.

Johns Hopkins Hospital's Medical Center in Baltimore is following in the footsteps of this Chinese tradition by training women from low-income neighborhoods to go door-to-door pushing for immunizations for children, according to a story in *American Medical News.*

This grassroots effort was fueled by a recent study that reported that 40% of Baltimore's under age 6 population has not received immunizations against tetanus, diphtheria, polio or measles.

"Mao's way of upgrading the health of the people of China was not with highly trained doctors, but with caring people," said Frank Oski, MD, head of the children's medical center. "Yet at the end of Mao's era, China had the highest immunization rate in the world."

Reading matter for the physician's spouse

As a physician, you know what you're up against — both in medical school and in practice. You know all about the rewards and the pitfalls. You know how to walk that fine line between sanity and insanity. But what about your spouse? Your family? Do they know what to expect from medicine?

The American Medical Association Auxiliary has recently published a series of booklets titled "What Every Physician's Spouse Should Know," as part of its ongoing effort to provide education and support to physician's spouses and their families.

Currently available are booklets on:

- Professional Liability — information on the scope of the problem, steps in the legal process, and how the family can cope.
- Impairment — examines some of the causes of impairment in both physicians and spouses, addresses the impact the problem has on the family, and provides resources for obtaining help.
- Survival Tips for Resident Physician/Medical Student Spouses — focuses on marriage during the training years and how to cope with the various stressors involved. Also included is information for the spouse on medical ethics, and setting up the physician's practice.
- Medical Marriage — focuses on how physicians and spouses cope with the special concerns of the training, practice and retirement years.

New this month is an additional booklet on Retirement and Estate Planning, which provides essential information on how physicians and spouses should plan for these two important phases of life.

The cost for all booklets in the series is $5 per copy (AMA Auxiliary members may take advantage of a special $3 per copy charge). To purchase, send prepaid orders to the AMA Auxiliary, 535 N. Dearborn St., Chicago, Ill. 60610.

Health education in schools

"Children exposed to health education show healthier attitudes and better health skills and practices," the Centers for Disease Control (CDC) reports.

CDC based its findings on a School Health Education Evaluation Program study of 30,000 students from 20 states over a two-year period. The study indicated that health education can have a "substantial" impact on young people's health attitudes, according to an article in *AARP Reporter.*

One example of a successful health education program is the School Health Curriculum Project, which teaches children about the hazards of smoking. The CDC study found that children exposed to this program were less likely to begin smoking. "In 1984, if all students in U.S. schools had been exposed (to the School Health Curriculum Project) . . . 146,000 students would not have begun to smoke," the CDC report predicted.



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OHIO MEDI-SCENE

An intern's view of a mini-internship and mini-intern programs around the state . . . AIDS Awareness Week . . . arthritis research at Cleveland . . . membership recruitment recognition . . .

An intern's view of a mini-internship

At least I didn't faint in surgery!

Don't laugh. For those of us who have never been in surgery and whose only experience with hospitals has been to visit friends who have given birth, remaining upright in surgery was a victory of sorts.

I spent a day in early February observing several surgical procedures as part of the mini-internship program arranged by the Montgomery County Medical Society. I was invited to participate because I have about a decade's worth of experience as a lobbyist but I am a newcomer to the medical profession. As the newly appointed Director of the Department of State Legislation for the Ohio State Medical Association, I wanted to know what a workday feels like for a physician.

Joining me in this internship program were four other interns from the Montgomery County community, each with his or her own distinctly different perspective on physicians and the practice of medicine. One among us was a successful plaintiff attorney whose specialty was medical malpractice claims. There was a chief financial officer from a corporation, a public affairs manager for a local television station, and a manager of a senior citizens center in Dayton. We interns shared two traits: none of us had had the opportunity to observe a physician in the daily course of practicing medicine, and each of us was employed in an occupation which had an impact on the shaping of health care policy.



Montgomery County's "interns" in white jackets sit in front of their physician mentors. (John Van Doorn is second from left, front row.)

We met our host physicians at the introductory dinner preceding our internship. Each intern was assigned to spend one day with primary care physicians and one day with hospital-based physicians. William Marshall, MD, chair of the mini-internship program for Montgomery County Medical Society, greeted the interns and

OHIO MEDI-SCENE

An intern's view . . . *continued*

their host physicians. Aside from the introductions, the purpose of the evening was for our host physicians to hear what the interns hoped to learn. As you might expect, each intern's expectation was influenced by his or her preconceived notions about medicine. For instance, the manager of the senior citizens center was interested in how quality health care would be delivered to the poor and elderly. After dinner, we received our white lab coats, had our photos taken, and were admonished about the confidentiality of the patients' relationships.

My first day was spent with primary care physicians at the offices of Dr. Stephen House, a family practitioner, and Dr. Philip Hughes, an ophthalmologist. Rather than bore you with details of the day, I want to report some of my impressions about my first experience "practicing medicine."

I was struck by the pace of the daily routine, much of it spent hopping from one office to the next, pausing only long enough to make the proper notations in the patient's records. Patients were extraordinarily cooperative about having an intern present, and they candidly revealed their physical problems as well as a good many emotional ones. (Several patients even referred to me as "doctor," and though we corrected their misimpressions, I must admit I was vicariously flattered.) In the course of those conversations between physician and patient, it was apparent that these physicians knew a lot about their patients. They inquired not just about the immediate physical problem, but they went beyond and asked about the patient's family and lifestyle. That interest in their personal problems, coupled with the physician's ability to heal, created a bond between these physicians and their patients which is perhaps unique.

My second day was spent at the Kettering Medical Center with Dr. David Small, a general surgeon, and Dr. Jeremias Andrews, a neuro-radiologist. For most of the day I observed surgeries.

During my visit with the primary care physicians, I had seen patients who were healing or healthy, a testament to the skill of modern medicine. Imagine my surprise when in the presurgery visit with his first patient, Dr. Small bowed his head and prayed with the patient. In the hall he explained to me that one reason he requests the prayer is to remind his patients that he and the modern medical technology at his disposal are not infallible. Later in the day I was again reminded that medicine is an imprecise science not always yielding to the will of highly skilled professionals when Dr. Andrews had some difficulty inserting catheters into desired arteries. (Dr. Andrews kidded me that he felt jinxed, temporarily, by my presence.) Another highlight involved a young man in severe back pain who required extensive testing on the hospital's magnetic resonance imager (MRI). The patient's insurance coverage wouldn't pay for such a test, so the physician made a personal appeal to the MRI administrators to allow the patient to be tested at the hospital's expense.

Much of what I witnessed in those two days may be commonplace to physicians. They made a lasting impression on me. Despite the economic restrictions placed on physicians, their focus was always on the finest quality care for their patients. I also came away with an appreciation for the intensity of a physician's workday, both the pace of the schedule and the intense emotions that physicians must feel treating people who are seriously ill and in pain. Adding to that intensity was the patients' belief that their physician could and would make them well, by performing medical miracles if necessary.

The last night of the internship was a dinner held to debrief the interns. Each intern was asked to discuss his or her impressions

"Much of what I witnessed in those two days may be commonplace to physicians. They made a lasting impression on me."

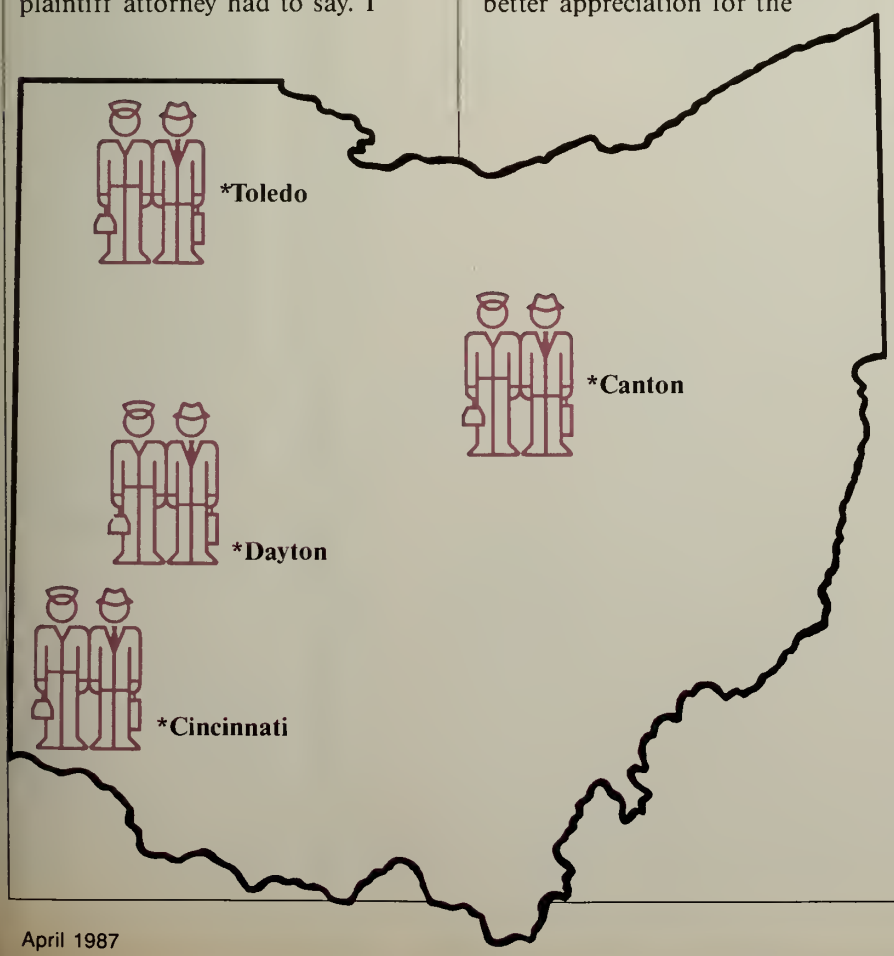
— John Van Doorn, intern
Montgomery County Medical Society

about their experience with the mini-internship committee members present. I was anxious to hear what the others' impressions were.

As you might expect, the corporate financial officer had examined the hospital administration and reported that he found it to be "generally efficient, but the utilization of the large, costly equipment could be more centralized and shared among hospitals to achieve greater efficiencies." His remark sparked discussion. The intern from the media had been a corpsman in the armed services 20 years before, so he was impressed by the many advances since his last familiarity with medicine. He had been moved to tears, he also related, by the delivery of a premature baby which he held immediately after birth.

I have to confess that I was especially eager to hear what the plaintiff attorney had to say. I suspected the physicians in the room were as eager as I was. He offered that he had gained an appreciation for aspects of the practice of medicine which he hadn't had before the internship. He felt that some of the things he learned would cause him to look at certain potential cases differently in the future. He cited a surgery he observed, a removal of a football-sized tumor from a man's abdomen. It was a long and difficult procedure. Toward the end of the surgery, as the surgeon strained to remove the last of the tumor he accidently nicked the patient's aorta. Within minutes the damage was repaired, and the tumor was completely removed. If that medical record had come across the attorney's desk just a few days ago, he would have accused the physician of being a "butcher." But now, he confessed, having witnessed the delicacy of the procedure, he felt he had a better appreciation for the intricacy of that surgery. (On the other hand, he also admitted that he had learned a few things that would be helpful in his practice.) The plaintiff attorney's better understanding of that surgery reinforced my last impression.

When properly done, mini-internships are an extraordinarily effective tool in teaching lay people about what being a physician is all about. In many cases, the physicians who act as hosts will have an ongoing relationship with their interns, answering future questions which may arise in the interns' occupations. In the immediate sense, interns leave their program with a far better understanding of the demands placed on the physician. Better understanding will surely foster better policy, both from private as well as public sources. Mini-internships are well worth the effort required by physicians who choose to participate. — *John Van Doorn*



Mini-internship programs in Ohio

There are presently four county medical societies which have set up mini-internship programs here in the state. Below is a brief description of each program and how it operates.

The Montgomery County Medical Society

This is the granddaddy of Ohio's mini-internship programs. Gerri Creel, Director of Communications, who coordinates the program for Montgomery County, credits William Marshall, MD, as instrumental in bringing mini-internships to Ohio. "He had read about a similar program in Portland, Oregon (the acknowledged originator of the mini-intern program), and felt it would be beneficial here as well," she says.

An ad hoc committee was formed which handpicked the

Mini-internship programs . . . *continued*

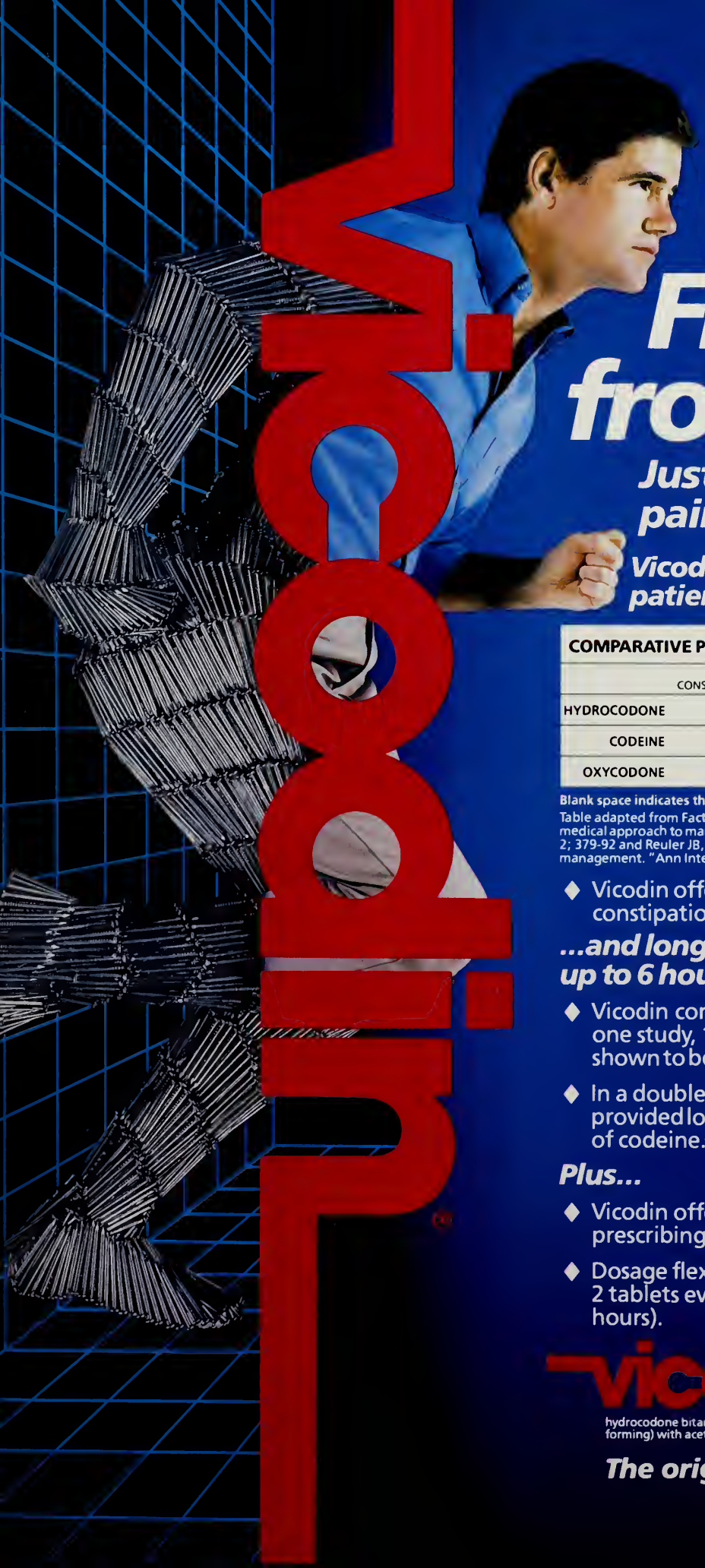
names of five community leaders — potential interns — who might benefit from such a program, as well as a list of possible physician-mentors. The program has grown tremendously ever since, says Creel. "It puts physicians in touch with the community, and allows those in the community to become more aware of the profession. It opens up the avenue of communications both ways."

Date of first session: October, 1984
Number of sessions to date: 8
Number of sessions held each year: 3
Number of interns through program to date: 38
Number of physician participants to date: 63
Occupations of interns: County commissioners; state representatives; news, science and editorial writers; local business leaders and employee benefit managers; labor leaders.
Solicitation of interns and physicians: largely through recommendations from those who have participated in the program, "but we try to keep the program in front of our members throughout the year, and many have signed up as a result," says Creel. Also from publicity generated.
Length of program: 2 days
Physician-intern pair-ups: one intern is paired with three different physicians — one office-based primary care physician for a full day and two hospital-based physicians for a half-day each.
Follow-up with interns: de-briefing session with physician-mentors. Both oral and written evaluations. Interns are also encouraged to maintain contact with their mentors and/or the medical society.
Next scheduled program: late April, 1987
For further information contact: Gerri Creel, Montgomery County Medical Society, 40 S. Perry St., Dayton, Ohio 45402 (513) 223-0990.

The Academy of Medicine of Cincinnati

The idea to initiate a mini-internship program in Cincinnati occurred at roughly the same time as it did in Montgomery County, claims Susan Clarke, the Academy's Director of Communications. "It just took us a little longer to get it off the ground," she says. The program was finally initiated by a steering committee composed of Lee Vesper, MD, who was then the Academy's President-Elect; Thomas Warner, MD (then the Academy's President); William Miller, MD (Public Relations Committee Chairperson); Executive Director William Galligan; and Clarke. The committee recruited its physician participants by contacting the president of each specialty society as well as the medical staff directors of all area hospitals for recommendations and for help in spreading the word about the program. The committee, as well as their contacts, then provided a list of potential interns — "people who would be open about medicine," says Clarke. Now the program has a waiting list of people who wish to participate on both sides. "We'll continue the program indefinitely," says Clarke. "It's popular with our doctors and there is a real commitment to the program on the part of our executive leadership." Any problems so far? "Not unless you count the intern who got lost on his way to the hospital and was late for surgery," says Clarke.

Date of first session: June, 1985
Number of sessions to date: 8
Number of sessions held each year: 3
Number of interns through program to date: 45
Number of physician participants to date: 90
Occupations of interns: business and legislative leaders; clergy; educators; media and consumer activists ("One consumer reporter didn't want to participate, but did anyway, telling us it would be an adversarial relationship. The reporter came out of the experience with glowing reports of the profession," Clarke recalls, adding, "of course, he fainted twice.")
Solicitation of interns and physicians: recommendations from those who have participated in the program, and publicity that has been generated ("One county medical society executive from Illinois is coming into our next program so she can set up a similar mini-internship in her home county," says Clarke.)
Length of program: 2 days
Physician-intern pair-ups: one



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CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975, 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
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Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
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Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
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The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

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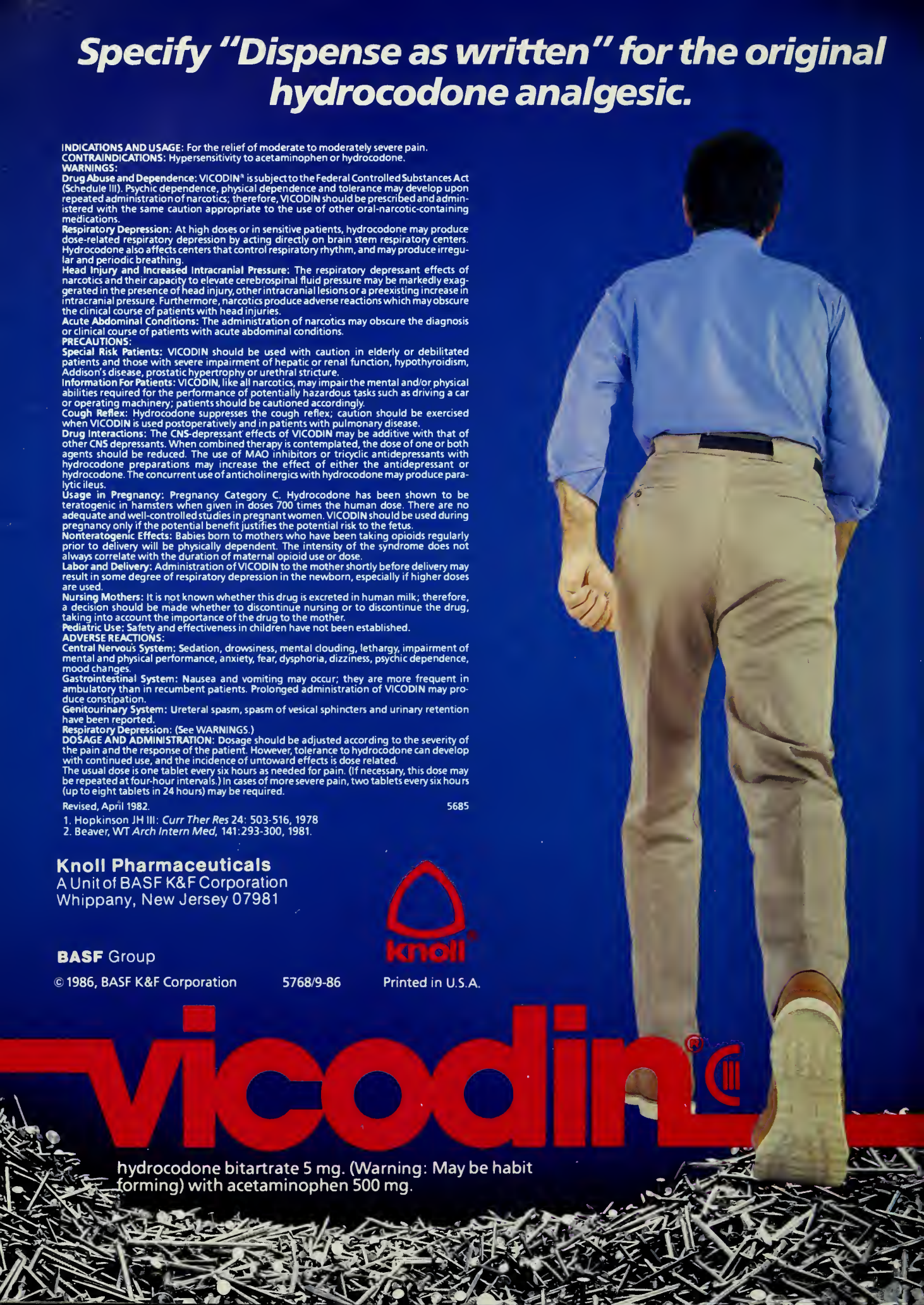
1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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intern is paired with four different physicians — one primary care; one emergency room; one surgeon; and one specialist — for half-day sessions.

Follow-up with interns: de-briefing session with physician-mentors. Both oral and written evaluations, plus one short evaluation the intern takes home to answer "when they've cooled off," says Clarke. Interns are encouraged to maintain contact, and many have, reports Clarke. "Some have served as guest speakers or panelists for us; one is presently serving on an Academy committee."

Next scheduled program: May 17-19, 1987

For further information contact: Susan Clarke, Academy of Medicine of Cincinnati, 320 Broadway, Cincinnati, Ohio 45202 (513) 421-7101.

The Academy of Medicine of Toledo

The mini-internship program began with the area's "very active" business coalition in mind. "We asked members of the coalition to be our first interns," says Jackie Venzel, Director of Communications at the Academy. From there, the program has grown substantially, although Venzel admits that their program continues to focus on the business community rather than trying to recruit interns from an assortment of professions. "We've had everyone in the coalition as interns now, so we're recruiting corporate executives and benefits people from outside the coalition." Despite its relatively low profile, Venzel says the mini-internship program "has been one of the most successful programs we've ever done here. We'll continue it as long as people want to participate."

Date of first session: December, 1985

Number of sessions to date: 4

Number of sessions held each year: 2

Number of interns through program to date: 15

Number of physician-participants to date: 45

Occupations of interns: business leaders; employee benefits managers.

Solicitation of interns and physicians: largely through recommendations from program participants and by invitation.

Length of program: 2 days

Physician-intern pair-ups: one intern is paired with three physicians — one office-based primary care physician for a full day and two hospital or office-based specialists for half-day sessions each.

Follow-up with interns: de-briefing session, but held separately — interns meet one night; physicians another. "That allows participants to express any negative feelings they have openly," says Venzel. Oral and written evaluation. Usually no further contact with interns following participation.

Next scheduled program: Fall, 1987

For further information contact: Jackie Venzel, Academy of Medicine of Toledo and Lucas County, 4428 Secor Rd., Toledo, Ohio 43623 (419) 473-3200.

Stark County Medical Society

The "new kid on the block," Stark County's mini-internship program began only after Executive Director Nancy Adams did a quick sales job. "I had heard about the program six years ago, at an association meeting I attended, and I brought the idea back to the society's board. The trouble was no one here had heard about it yet," says Adams. The idea was temporarily shelved until last June when Adams learned of Cincinnati's new program. "Susan (Clarke) invited me down as a participant, and I went." This time, Adams had firsthand experience to bring back to her board — and the board finally bought the idea. The society's president, president-elect, public relations committee chairperson and Adams sat down and came up with names of possible physician participants. They turned to members of the area's health-care coalition for intern possibilities. Now, it would be difficult to find a program whose participants are more enthusiastic than Stark County's. There is a waiting list of individuals who want to participate, says Adams, and the program's success is unquestioned. "We have heard no bad comments. It is, without a doubt, the best PR we've ever done, and certainly it's been the most successful program we've had since I've been here," says Adams. Do they plan to continue it? "Until we run out of interns," responds Adams with a laugh.

Date of first session: April, 1986

Number of sessions to date: 5

Number of sessions held each year: 4

Number of interns through program to date: 19

Number of physician participants to date: 36

Occupations of interns: business leaders; bank leaders; trial lawyers; union presidents; employee benefits managers; hospital board of trustee members.

Solicitation of interns and physicians: through recommendations from those who have participated in the program and publicity generated.

Length of program: 2 days

Physician-intern pair-ups: one intern with three or four physicians ("it depends on the specialty," says Adams) — half-day with an office-based primary-care physician; half-day with a specialist; and usually a full day with a surgeon.

Follow-up with interns: de-briefing session with physician-mentors. Both oral and written evaluations. Interns are encouraged to maintain contact with their mentors and/or the medical society.

Next scheduled program: June or July, 1987

For further information contact: Nancy Adams, Stark County

continued on page 264

OHIO MEDI-SCENE



The above poster featuring Patti LaBelle is part of a country-wide effort to focus attention on AIDS and its prevention through education. The Ohio Department of Health is planning its own education campaign next month.

AIDS awareness week planned

"An ounce of prevention . . . because there is no cure."

That's the sentiment that will kick off "AIDS Awareness Week" (May 11-14) — an attempt by the Ohio Department of Health (ODH) to familiarize everyone in the state with the facts — as opposed to the myths — on AIDS.

"There are between 30,000 and 40,000 people in the state who are infected with AIDS. Many don't even know they are," says Tom Halpin, MD, (Acting) Director of the Ohio Department of Health (see related article in this issue). That's why he and the state health department feel so strongly about getting a public education campaign off the ground.

"Education is the only way to prevent AIDS," says Robert Campbell, Project Supervisor of the AIDS Activities Unit at ODH. Since vaccines and cures are still "years down the road, education is the only game we have right now."

Education is a "game" that already has been "played" successfully in other states. Both Connecticut and Michigan have held successful "Awareness Weeks," and San Francisco has an ongoing project which includes the regular airing of TV public service announcements made by such personalities as Bob Hope, Linda Grey, Joe Namath and Pat Benatar.

"The fear comes from not knowing much about AIDS," says Lois Hall, Project Coordinator, AIDS Surveillance, ODH, and Chairperson of the "AIDS

Awareness Week'' Planning Committee.

As she points out, however, medicine has learned a lot about AIDS in the past few years, ''and we need to get that information out. People need to know how AIDS is transmitted — and how it is *not* transmitted; what puts them at risk and what doesn't.''

ODH staff members are well aware, however, of the public's reluctance to learn more on the subject — that tendency, as Dr. Halpin puts it, ''for people to want to put their head in the sand.''

''People *are* hesitant to come out for information on AIDS,'' agrees Hall.

That's one of the reasons the department has begun to print a ''blind'' leaflet on the subject — one that doesn't shout ''AIDS'' from either its front cover or its back.

''The person who would be too embarrassed to be seen with AIDS literature can pick this up and carry it around without being noticed,'' says Hall.

Of course, part of the embarrassment which surrounds any discussion of AIDS comes from the misconception that AIDS afflicts homosexuals only.

''It's a myth that AIDS is a gay disease,'' says Hall. ''People who think that are wrong. It is a disease of sexually active adults and teens; it's a disease of a needle-sharing population.''

That's the word the ODH would like to see spread — especially to the drug community.

''Kids are especially at risk,'' says Hall. First-time IV drug users are not apt to have their own fresh needle with them at parties where much drug experimentation usually occurs. As a result, they end up sharing needles — and, as it often turns out, end up sharing AIDS as well.

Of course, financially speaking, AIDS has become a cost problem as well.

According to Richard Wittenberg, ODH's Chief of Legislation and Public Relations, the medical costs of treating AIDS have risen substantially. Some estimates now place the price tag as high as $140,000.

''Blue Cross companies in New York have already paid $20 million in AIDS cases,'' says Wittenberg, adding that the national figure for AIDS care is estimated to be between $8 and $16 billion.

The cost consideration, however, is just *one* more reason why the AIDS Awareness Week is thought to be so important.

''It's a myth that AIDS is a gay disease. People who think that are wrong. It is a disease of sexually active adults and teens; it's a disease of a needle-sharing population.''

— Lois Hall
Ohio Department of Health

''Ohio is at the beginning of its epidemic,'' says Hall. ''We are two to four years behind New York, San Francisco and other large cities — but we need to work to stay ahead of where they were.''

Maybe ''AIDS Awareness Week'' is just the ''ounce of prevention'' needed to keep Ohio ahead in the nation's battle against this complex — and killing — disease. — *Karen S. Edwards*

Cleveland researchers take aim at arthritis

The burden and pain associated with rheumatoid arthritis may be eased in the future if a study underway at the Cleveland Clinic Foundation bears fruit. Researchers there are investigating an FDA-approved process called cryofiltration, an attempt to remove abnormal antibodies from the blood before they can be deposited in the joints. The process was developed by the clinic's Department of Artificial Organs in conjunction with the Parker Hannifin Corporation.

The process cryofiltration — or *cold* filtration — is a double-filtering process of the blood, says John D. Clough, MD, Chairman of the Department of Rheumatic and Immunologic Disease at the clinic. The first filter separates the blood cells from the plasma. The plasma is then cooled and passed through a second filter which traps enlarged molecules — among these are immune complexes which aggregate and enlarge when cooled, he explains.

Dr. Clough adds, however, that the study is *not* designed to show whether cryofiltration can prevent or reverse joint inflammation. Instead, its success lies in ''whether the process is effective in decreasing inflammation and improving functional capacity.''

Currently, 10 arthritis patients are participating in the study, which has been underway for about one year. At the onset of treatment, a patient typically undergoes the cryofiltration process two to three times per week. After a few weeks, treatments taper off to about once a month.

Dr. Clough and his colleagues are looking for about 20 more volunteers for the study, but they must meet specific criteria. ''This particular study is focusing on the most severe cases,'' he explains. In addition, Dr. Clough requests that volunteers have previously failed two other drug regimens — either because the drugs were ineffective

OHIO MEDI-SCENE

Cleveland researchers

continued

or too toxic. "We are quite anxious to recruit more volunteers for treatment at no charge," he adds.

Dr. Clough and other clinic researchers previously published findings in which about 20 participants reported a good response to the cryofiltration treatment. The study, however, was an uncontrolled one; and "because there is a strong possibility of placebo effect, we felt we had to do a *controlled* study," he explains.

Clinic researchers are collaborating with a group of researchers from the Tokyo Tokatsu Clinic in Japan who are providing the bulk of the funding for the clinic's study, as well as conducting a parallel study using the same criteria. At the close of the two studies, the groups will compare findings and may even pool results.

Dr. Clough's outlook on the study is optimistic. "Because of its safety as compared to some (arthritis) drugs — if it (the process) is successful — it may become widely used for patients with severe arthritis," he says. If so, the cost of such a procedure will become more manageable, and, like dialysis, may someday be performed at home.

Individuals interested in more information about the study should contact Dr. Clough at (216) 444-5627, or Holly Jinks, RN, (216) 444-5631. — *Deborah Athy*

Ohio physicians receive AMA recognition

Recently eight Ohio physicians received recognition for AMA membership recruitment at Las Vegas in the American Medical Association House of Delegates Outreach Program.

Donavin A. Baumgartner, Jr., MD, of Cleveland was one of five physicians receiving a second consecutive year award. Dr. Baumgartner, in the tan wool blazer received as his award, is shown below with Dr. John Lee Clowe, Vice Speaker, AMA House of Delegates.



Dr. William T. Paul of Columbus, who recruited nine AMA members, was one of 26 other physicians nationwide earning a wool blazer.

Six Ohio physicians who received Honorable Mention awards are:

***Alford C. Diller, MD,* Van Wert**
***Ray W. Gifford, Jr., MD,* Cleveland**
***Jerry L. Hammon, MD,* West Milton**
***William J. Marshall, MD,* Dayton**
***Thomas W. Morgan, MD,* Gallipolis**
***Richard V. Nowak, MD,* Cleveland**

Ohio State Medical Association also received its tenth consecutive year award for AMA membership increase. This award is directly related to the efforts of the above physicians and others who are committed to membership recruitment. — *Katherine Wisse*

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We're encouraging all area urologists to apply for privileges in Extracorporeal Shock Wave Lithotripsy. We invite you to visit CAMC and see the lithotripter in action. Come and learn about this revolutionary therapy. We will happily provide you with a brochure for your use as well as brochures for your patients.

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AIR FORCE



The Spirit of Caring

September 4, 1986

Herbert Gillen
Executive Director
Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215

Dear Mr. Gillen:

The Academy of Medicine of Cleveland is pleased to nominate Donavin A. Baumgartner, Jr., MD as a candidate for President-Elect of the Ohio State Medical Association. Dr. Baumgartner has a long history of constructive involvement in organized medicine on behalf of the physicians in the greater Cleveland area, Ohio, and throughout the United States. Locally, Dr. Baumgartner served as a member of the Board of Directors of the Academy of Medicine of Cleveland from 1972-1981 and as its President in 1979-80. He has previously served as chairman of numerous committees including the Professional Liability, Nominating, Resolutions and Travel Committees. Currently Dr. Baumgartner chairs the Membership Committee and has been recognized by the American Medical Association for his outstanding recruiting efforts. He has also been a leader in recruiting medical students and residents as involved members of medical associations. Dr. Baumgartner also serves his local medical society as a member of the Ethics Committee, Trauma Committee and Publications Committee. He is also on the Board of Trustees of the Cuyahoga County Medical Foundation.

At the Ohio State Medical Association, Dr. Baumgartner has served since 1983 as Fifth District Councilor. He is chairman of the Audit and Appropriations Committee and a member of the Task Force on Professional Liability, Membership Committee and Chairman of the Subcommittee on Resident Recruitment. In 1985 Dr. Baumgartner was elected as an alternate delegate to the American Medical Association.

In 1983, he was a speaker at the AMA National Leadership Conference and spoke on the subject of Resident Recruitment and Retention. In 1986, he again spoke at the AMA National Leadership Conference on the subject of the Physician Role in Recruitment.

Dr. Baumgartner is a fellow in the American College of Emergency Physicians and is certified by the American Board of Surgery and by the American Board of Emergency Medicine.

The Academy of Medicine of Cleveland and the Ohio State Medical Association have benefitted greatly from Dr. Baumgartner's understanding of medicine's challenges and opportunities as well as his outstanding ability as a leader. He is well qualified to serve as President-Elect and ultimately as President and we are proud to nominate Dr. Baumgartner as a candidate for President-Elect of OSMA.

Sincerely,
Daniel A. Deutschman, MD
President
Academy of Medicine of Cleveland

Candidate for President-Elect

Donavin A. Baumgartner, Jr., MD



Donavin A. Baumgartner, Jr., MD, received his medical degree from Harvard Medical School in 1956 — four years after receiving a BA from Princeton University. A Cleveland native and son and grandson of Ohio physicians, Dr. Baumgartner returned to his hometown where he completed both his internship and one year of a surgical residency at the University Hospitals of Cleveland, before going back to Massachusetts General Hospital to finish his residency training. He is certified by the American Board of Surgery and the American Board of Emergency Physicians.

Dr. Baumgartner now practices surgery at St. Luke's Hospital in Cleveland, where he also serves as the Medical Director of Emergency Services and as the Director of its Division of Trauma in charge of the Level I Trauma Center. He has surgical privileges, as well, at Hillcrest Hospital, Metropolitan General Hospital and Geauga Community Hospital.

An active participant in organized medicine, Dr. Baumgartner has also served on numerous committees of the Academy of Medicine of Cleveland, including terms as Chairman of the Academy's Professional Liability, Honors, Nominating, Resolutions and Membership Committees. He was the assistant editor of the *Cleveland Physician* for eight years and served as Academy President from 1979-1980.

Of course, Dr. Baumgartner's activity at the state level has been just as varied. He has served as Cuyahoga's delegate to the OSMA since 1972, and has been Fifth District Councilor since 1983. He presently serves as Chairman of OSMA's Committee on Auditing

and Appropriations and is involved with the hospital medical staff section. His early interest in professional liability has expanded to the state level as well, where he now serves as a member of OSMA's Task Force on Professional Liability. In addition, Dr. Baumgartner has assumed an active role in getting others interested in the OSMA. He serves on both the OSMA's Membership Committee and as Chairman of its Subcommittee on Resident Recruitment. He also finds time to serve as one of OSMA's Alternate Delegates to the AMA.

Organized medicine does not account for *all* the time Dr. Baumgartner devotes to outside activities, however. He is a senior instructor in surgery at Case Western Reserve University; lectures and supervises medical students and residents rotating through St. Luke's Emergency Room; and is an instructor in both Advanced Trauma and Advanced Cardiac Life Support.

A founding member of the Greater Cleveland Society of Emergency Physicians, Dr. Baumgartner is also a Fellow of the American Association for the Surgery of Trauma, an active participant in the Cleveland Surgical Society, Medical Arts Club, the American Trauma Society, and is now President of the Board of Consultants, Cleveland Safety Forces.

Outside the medical arena, Dr. Baumgartner is an avid oenophile, and his interests in this area will be the subject of a future "Out of Practice" column in *Ohio Medicine.*

Dr. Baumgartner and his wife Marilyn reside in Moreland Hills, Ohio, and have three children — Donavin III, Karen Lynn and Peter Hoffman — as well as two grandchildren, Donavin IV and Erika.

Next month in Ohio Medicine:



Is it legal, is it ethical . . . and who is doing drug testing in the state? Find out in the May issue . . .

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Professional Use Information

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CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic)

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS

General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histalogical changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg bosis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 7/86

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References: 1. *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983, 106(6):1341-1347.* ***2.*** *Shapira W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984,24(Dec):150-159.* ***3.*** *Johnston DL, Lesaway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectaris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687.* ***4.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***5.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.*

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The Annual Meeting Format & Schedule

FRIDAY, MAY 15

OSMA COUNCIL MEETING/ BREAKFAST
8:30 AM
Morrow Room, Ohio Center
OSMA INFORMATION DESK
9:00 AM-3:00 PM
Clark Foyer, Ohio Center
OSMA DELEGATION TO AMA MEETING
1:00 PM
Fayette Room, Ohio Center
HOSPITAL MEDICAL STAFF SECTION MEETING
1:00 PM
Franklin A, B, C, D, Ohio Center
OMPAC BOARD MEETING
2:30 PM
Madison Room, Ohio Center
RESOURCE CENTER
3:00-7:00 PM
Clark Foyer, Ohio Center
HOUSE OF DELEGATES
3:00-7:00 PM
Registration, Clark Foyer, Ohio Center
6:00-6:45 PM
Sit-down Dinner, Union A-E, Ohio Center
7:00 PM
Opening Session, Regency Ballroom, Ohio Center

ORDER OF BUSINESS OPENING SESSION

Call to Order
John E. Albers, M.D., Cincinnati
President
Invocation
Welcome
William A. Millhon, M.D., Columbus
President, Academy of Medicine of Columbus and Franklin County
Parliamentarian
W.J. Lewis, M.D., Dayton
Report
Committee on Credentials
Consideration of Minutes of 1986 Annual Meeting
(See August 1986 issue of The Ohio State Medical Journal)
Introduction of Member, AMA Board of Trustees
Introduction of Presidents of other State Societies
Introduction of Honored Guests
Introduction of Representatives of Allied Organizations
Membership Outreach Program
Thomas W. Morgan, M.D., Gallipolis
Chairman
Auxiliary Report
Mrs. Nora Feezel, Canton
OSMA Auxiliary President
AMA-ERF Presentations
John E. Albers, M.D.
President
Presentation of Plaques
To past Councilors, retiring AMA Delegates and Alternates and Chairmen of Committees
Announcement
John E. Albers, M.D.
Appointments to Resolutions Committees, Credentials, and Tellers and Judges of Election Committees
Election of Committee on Nominations
Nominations from the floor. One representative (delegate) from each Councilor District. The committee shall report to the second and final session, Sunday, May 17, 1:00 p.m., its recommendations in the form of a ticket containing nominees for offices to be filled at this meeting as required under the Constitution and Bylaws. Under the rotation plan established in 1963, the committeeman from the Second District shall serve as Chairman. The report of the Nominating Committee with respect to all offices except President-Elect shall be posted at least three hours before the final session of the House of Delegates.
Presidential Address
John E. Albers, M.D.
Special Order of Business
Memorial Resolutions
Introduction of Resolutions
Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Sunday afternoon session before any action can be taken.
Committee on Emergency Resolution Report
Miscellaneous Business
COUNCILOR DISTRICT CAUCUS MEETINGS
4:00-5:30 PM
Locations to be posted at Registration Desk
FOLLOWING HOUSE OF DELEGATES
Reception hosted by Physicians Health Plan, Columbus
Franklin A & B, Ohio Center

SATURDAY, MAY 16

REFERENCE COMMITTEES
7:00 AM
Breakfast, Union A-E, Ohio Center
8:00 AM-11:30 AM
Hearings, Ohio Center
Committee No. 1, Franklin C & D
Committee No. 2, Franklin A & B
Committee No. 3 & President's Address, Delaware D
Nominating Committee, Fayette Room
9:00 AM-Midnight
Writing Reports, Ohio Center
Committee No. 1, Fayette Room
Committee No. 2, Board Room #3
Committee No. 3 & President's Address, Board Room #1
OSMA INFORMATION DESK
8:00 AM-5:00 PM
Clark Foyer, Ohio Center
RESOURCE CENTER
9:00 AM-3:00 PM
Clark Foyer, Ohio Center
OMPAC
11:15 AM-1:30 PM
Social Hour & Luncheon
$20 per person
Regency South, Ohio Center
CANDIDATE INTERVIEWS
2:30-5:00 PM
Schedule and times will be posted at registration

OSMA SOCIAL FUNCTION
7:00 PM
COSI After Dark
$35 per person

SUNDAY, MAY 17

OSMA INFORMATION DESK
8:00 AM-5:00 PM
Clark Foyer, Ohio Center
COUNCILOR DISTRICT CAUCUS MEETINGS
8:00 AM-12:00 Noon
Locations to be posted at Registration Desk
HOUSE OF DELEGATES
11:30 AM
Registration, Ballroom Foyer, Ohio Center
1:00 PM
Final Session, Regency Ballroom, Ohio Center

FINAL SESSION ORDER OF BUSINESS

Introduction of Guests
Report of Committee on Credentials
Election of President-Elect
Report of Committee on Nominations and Election of Other Officers
Election of Members of The Council
Members of The Council are elected for two-year terms; terms of those representing the even-numbered districts expire in odd-numbered years. Second District: Incumbent, William R. Marshall, Dayton; Fourth District: Incumbent, John A. Devany, Toledo; Sixth District: Incumbent, J. James Anderson, Youngstown; Eighth District: Incumbent, John F. Kroner, Jr., Athens; Tenth District: Incumbent, H. William Porterfield, Columbus; Twelfth District: Incumbent, Joseph L. Kloss, Akron (not eligible for re-election).
Election of Delegates and Alternates to the AMA
Nine Delegates and Eight Alternates to be elected for a two-year term starting January 1, 1988, in compliance with the Constitution and Bylaws of the American Medical Association. The following incumbent Delegates and Alternates will serve for the remainder of 1987, their terms expiring December 31, 1987.
Delegates (listed alphabetically):
John E. Albers, Cincinnati; Oscar W. Clarke, Gallipolis; Alford C. Diller, Van Wert; William Dorner, Jr., Akron; John J. Gaughan, Cleveland; B. Leslie Huffman, Jr., Maumee; Joseph Sudimack, Jr., Warren. Also, two additional Delegates to be elected for a term commencing 5/17/87 and ending 12/31/87, replacing Drs. Ford and Gifford.

Alternates (listed alphabetically):
David A. Barr, Lima; Donavin A. Baumgartner, Jr., Cleveland; John A. Devany, Toledo; Stanley J. Lucas, Cincinnati; Richard J. Nowak, Cleveland; William T. Paul, Columbus; Carl E. Spragg, New Concord; J. Hutchison Williams, Columbus; Stephen Gilreath, Cincinnati, Medical Student Section Representative.
All nominees for the offices of AMA Delegates and Alternate Delegates of the AMA shall be governed by Section 7, Chapter 5, of the OSMA Constitution and Bylaws as revised by the House of Delegates in May 1971.

SPECIAL ORDER OF BUSINESS

Installation of 1987-1988 Officers
Reports of Reference Committees
Resolutions Committee No. 1;
Resolutions Committee No. 2;
Resolutions Committee No. 3 and President's Address.
Miscellaneous Business
Announcements
D. Ross Irons, M.D., Bellevue
President
Unfinished Business
Adjournment
6:00 PM
Dinner, Union A-D, Ohio Center
7:00 PM
Resume Final Session
Regency Ballroom, Ohio Center
RESOURCE CENTER
12:00 Noon-5:00 PM
Clark Foyer, Ohio Center

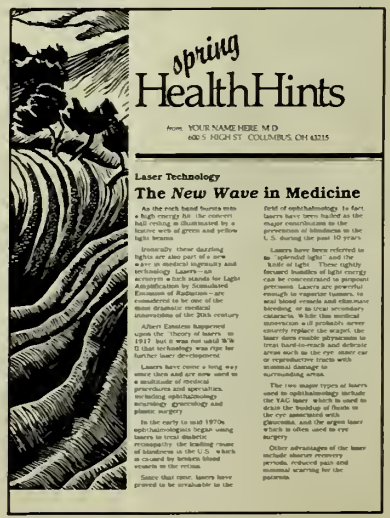
MONDAY, MAY 18

OSMA COUNCIL MEETING/ BREAKFAST
8:30-10:00 AM
Marion Room, Ohio Center
PICO SHAREHOLDERS MEETING
10:00 AM
Knox Room, Ohio Center

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Resolutions Affecting OSMA Bylaws

SPECIALTY SOCIETY REPRESENTATION
(Introduced by:
Wm. F. Ruschhaupt, MD,
Cleveland)

WHEREAS, OSMA and the specialty societies wish to achieve closer ties; and

WHEREAS, The OSMA amended its Bylaws to establish a procedure for seating a representative for each eligible specialty society in the House of Delegates; and

WHEREAS, The seating of specialty society delegates created some confusion at the 1986 Annual Meeting; therefore be it

RESOLVED, That the OSMA amend its Bylaws to clarify the procedure for seating specialty society representatives; and be it further

RESOLVED, That the Bylaws be amended as follows:

BYLAWS
CHAPTER 4
THE HOUSE OF DELEGATES

Section 3. Representation of Medical Specialties. All primary medical specialties listed by the American Board of Medical Specialties are eligible to apply for representation in the House of Delegates.

To be eligible, the specialty society or societies in the section initially must have 50% of their physicians WHO ARE ACTIVE MEMBERS UNDER THE SPECIALTY SOCIETY'S BYLAWS as members of the OSMA; at the end of its third year of representation, 75% OF THE SPECIALTY SOCIETY'S ACTIVE MEMBERS MUST HOLD MEMBERSHIP IN THE OSMA ~~OSMA membership has to be achieved.~~ IF THE 75% MEMBERSHIP IS NOT ACHIEVED IN ANY GIVEN YEAR, THE SPECIALTY SOCIETY'S DELEGATE SHALL NOT BE SEATED IN THE HOUSE OF DELEGATES THAT YEAR. ~~If for three (3) consecutive years thereafter this percentage is not maintained, then delegate status is terminated.~~

A Medical Specialty SOCIETY ~~Section~~ seeking representation shall apply to the Council. The Council shall consider applications and then recommend to the House of Delegates whether the specialty society qualifies for representation.

Each recognized Medical Specialty SOCIETY ~~Section~~ shall have one delegate and alternate who must be members of the Ohio State Medical Association. Each specialty SOCIETY ~~section~~ will certify to the Association at least sixty (60) days prior to the Annual Meeting both the names of its delegate and alternate and its ACTIVE membership ROSTER ~~certification as required by subsection (b) above.~~ THE OSMA SHALL NOTIFY THE SPECIALTY SOCIETY WITHIN THIRTY (30) DAYS OF THE PERCENT OF ITS ACTIVE MEMBERSHIP ROSTER WHICH HOLDS MEMBERSHIP IN THE OSMA. IF 75% OSMA MEMBERSHIP HAS NOT BEEN MET, THE SPECIALTY SOCIETY CAN CONTINUE TO SUBMIT NAMES FOR REVIEW UP UNTIL THE ANNUAL MEETING, WITH A RECOMMENDATION ON DELEGATE STATUS BEING MADE BY COUNCIL PRIOR TO OPENING SESSION OF THE HOUSE OF DELEGATES. COUNCIL'S RECOMMENDATION SHALL BE SENT TO THE HOUSE OF DELEGATES FOR FINAL ACTION.

A Medical Specialty SOCIETY ~~Section~~ delegate shall have all rights, privileges and duties as other delegates. The delegate will be seated in the House of Delegates with the councilor district in which his/her county medical society is represented.

Failure to comply with Section 3, Chapter 4 shall result in loss of representation. That determination shall be made by the Council, with appeal provided to the House of Delegates.

MEDICAL SPECIALTY SOCIETY REPRESENTATION (Introduced by Ohio Academy of Family Physicians)

WHEREAS, Amended Resolution 11-82 amended the Bylaws of the Ohio State Medical Association to provide for Medical Specialty representation in the House of Delegates, including, in part, the following: "To be eligible, the specialty society or societies in the section initially must have 50% of their physicians as members of the OSMA; at the end of the third year of representation, 75% OSMA membership has to be achieved. If for three consecutive years this percentage is not maintained, then delegate status is terminated"; and

WHEREAS, one of the purposes of this amendment was to increase membership in OSMA; and

WHEREAS, currently, only 45% of the United States' population of physicians are members of the AMA and only 68% of all physicians in Ohio — active, retired and disabled — are members of the OSMA; and

WHEREAS, the 75% OSMA membership requirement excluded representation in the 1986 House of Delegates by Medical Specialty Societies representing Anesthesiology, Family Practice, Internal Medicine, Pathology and Psychiatry, effectively disenfranchising specialty representation for a significant percentage of the OSMA membership; and

WHEREAS, the leadership of Ohio's specialty societies have exerted their best efforts to increase the percentage of their societies' membership in OSMA and to counter disenrollment in OSMA by their membership as an understanding but counterproductive reaction to disenfranchisement from the OSMA House of Delegates; and

WHEREAS, to date, neither the 1986 House of Delegates nor any of the appropriate Committees, Council, Executive or leadership of OSMA has taken any concerted official action(s) to redress what may be an unrealistic, possibly discriminatory, but certainly counterproductive provision of the Bylaws; now therefore be it

RESOLVED, that the Bylaws of the Ohio State Medical Association be amended to provide Medical Specialty representation in the House of Delegates as follows:

Chapter 4: The House of Delegates

Section 3: Representation of Medical Specialties . . .

To be eligible, the specialty society or societies in the section initially must have 50% of their physicians as members of OSMA; at the end of its third year of representation, ~~75% OSMA membership has to be achieved~~ *ITS PERCENTAGE OF OSMA MEMBERSHIP MUST EQUAL THE PERCENTAGE OF THE TOTAL PHYSICIAN POPULATION IN OHIO WHO ARE MEMBERS OF OSMA, CALCULATED AS OF JANUARY 31, EACH YEAR.* If for three consecutive years thereafter this percentage is not maintained, then delegate status is terminated.

Ohio State Medical Association

Hospital Medical Staff Section

Annual Meeting **May 15, 1987**

Hyatt Regency Columbus

1:00 p.m. - 1:30 p.m. Business Meeting

1:30 p.m. - 3:30 p.m. Panel Discussion

"PRO Review Process & Sanctions"

featuring

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Barbara Gagel; Regional Administrator, HCFA, Region V

For more information call: Douglas Graff, J.D.
Ohio State Medical Association 614/228-6971



Vern Riffe

VERN RIFFE

Speaker

Ohio House of Representatives

To Address OMPAC Luncheon

Saturday, May 16

Reception: 11:15 AM
Regency South Foyer

Luncheon: 12 Noon
Regency South Ballroom

Hyatt Regency Hotel
Columbus, Ohio

Vern Riffe, Speaker of Ohio's House of Representatives, will be the featured lecturer at the OMPAC Luncheon, to be held Saturday, May 16, during the OSMA Annual Meeting in Columbus.

Speaker Riffe will discuss the Ohio political scene, and the present liability crisis, drawing from his experience as House Speaker and the leader of that chamber's Majority Party.

This year, Speaker Riffe achieved the national distinction of becoming the longest-serving speaker currently presiding in our nation today — an achievement he earned in the state in 1983.

As the House Speaker, Speaker Riffe also serves as Chairman of the powerful Rules Committee, and as an ex officio member of all House standing committees. In addition, Speaker Riffe presently serves as Chairman of the Legislative Service Commission.

To make reservations to attend the OMPAC luncheon, please complete the attached form and return it with your check for $20 for each ticket to the Ohio State Medical Association.

OMPAC LUNCHEON RESERVATIONS
OSMA ANNUAL MEETING

PLEASE PRINT

Saturday, May 16, 1987

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Members of 1987 OSMA House of Delegates



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Delegate:
Charles W. Hannah
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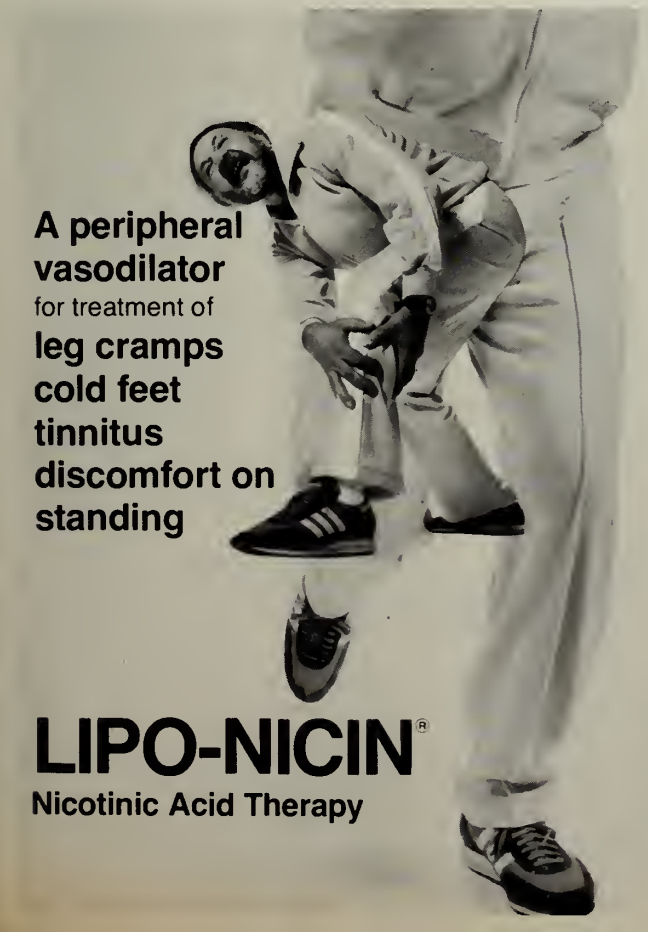
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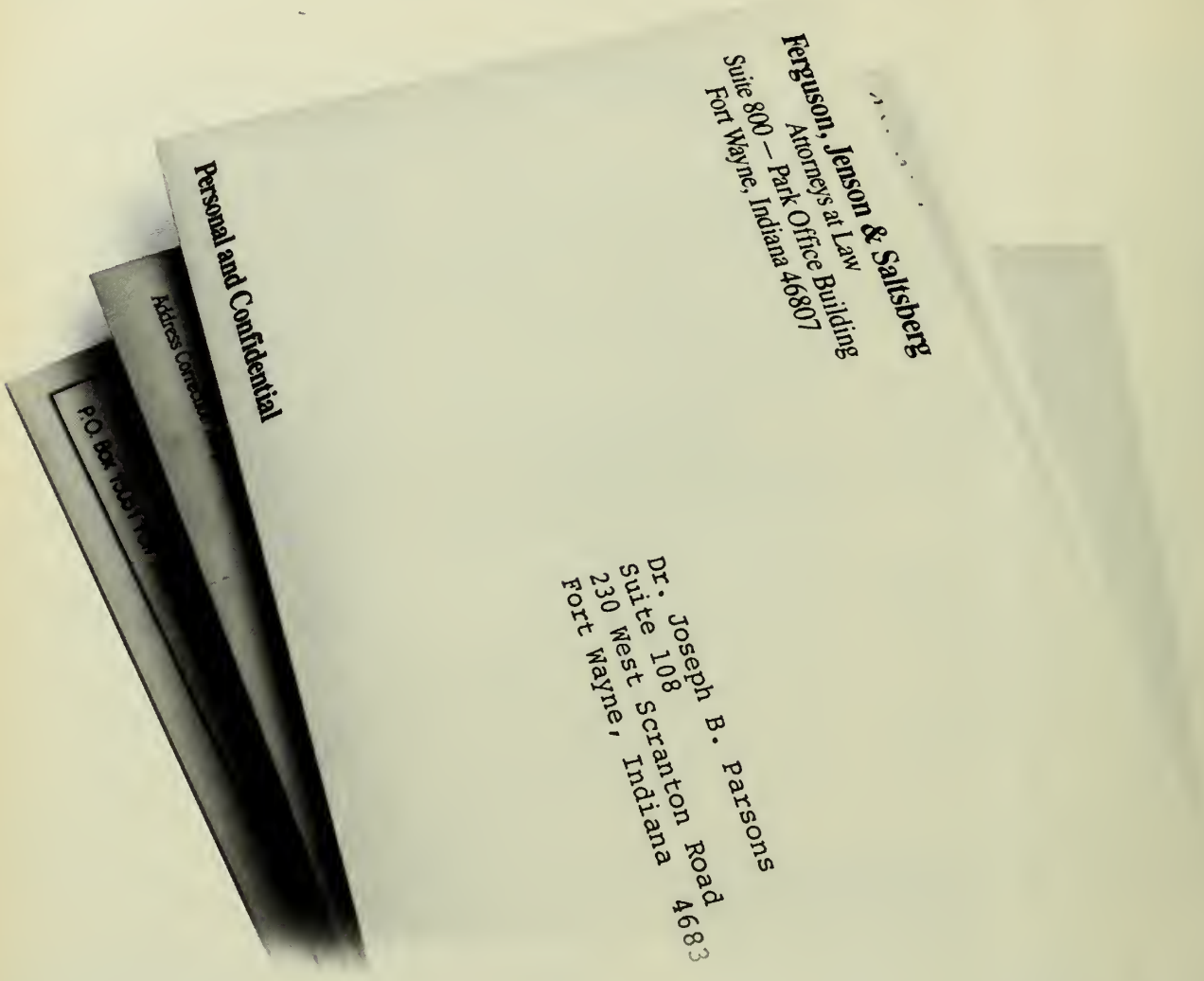
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Resident Physician Committee Report

By Warren Ljungren, MD

Resident Physician Committee Formed

The Resident Physician Committee of the OSMA was created in 1986 to address the needs and concerns of OSMA resident members. The charter members of the committee represent residents from six out of eight counties that have programs in Ohio.

Resident Section Recommended

The Committee's recent survey of resident OSMA members showed overwhelming support for creating a resident "section" within OSMA. Such an organization would strengthen resident representation providing a more direct vehicle for discussing resident issues.

Resolution Approved by Council

The OSMA Council supports the committee's efforts to strengthen the residents' voice within organized medicine in Ohio. Recently, Council member John Devany, MD, from District 4, and Stanley Lucas, MD, from District 1, were appointed as official advisors to the Resident Physicians Committee. Furthermore, Council has approved a resolution for the creation of an "RPS" to be brought before the OSMA House of Delegates at the Annual Meeting in May, 1987. Passage of this resolution would allow one resident to sit as a non-voting member in Council as well as electing one delegate and alternate to the House of Delegates.

Highlights of the Survey

Out of 2,400 surveys mailed to resident physicians in the state, 430 were received, giving an 18 percent — better-than-average — response rate. Of particular interest were the following items:

1. **81 percent favored creation of an RPS**
2. **The majority could offer between three and five days per year participating in activities of a resident physician section.**
3. **The most important problems facing residents today in the state of Ohio are:**
   a. too many outside demands
   b. quality of the work environment
   c. funding of graduate education
4. **Services offered by OSMA that would be most beneficial are:**
   a. financial and tax-planning seminars
   b. starting your practice seminars
   c. contract negotiations
5. **The top three priorities in residents' lives are:**
   a. enjoying a balanced lifestyle
   b. completing the certification process
   c. establishing and building a practice
6. **The top priorities of organized medicine should be:**
   a. resolving liability issues
   b. reducing government regulation
   c. advocating high quality of care

RPS Action Plan

Here is a brief look at the events in the near future:

April 11 — The resident physician committee reconvenes to draw up bylaws for the proposed section.

May 15-17 — The "RPS" resolution is introduced to the OSMA House of Delegates.

June 19-21 — Annual AMA Business Meeting in Chicago with delegates attending from Ohio.

July-August — Establishment of the governing council of the newly formed section.

An Interactive Network for the Future

The Resident Physician

continued on page 264

County Medical Societies

Officers, Executive Directors and Meeting Dates

FIRST DISTRICT

Councilor: *Stanley J. Lucas, M.D.,* 2905 Burnet Ave., Cincinnati 45219.

ADAMS: Dale L. Mathias, Jr., M.D., President and Secretary-Treasurer, 195 Hopping Ave., Peebles 45660-1079. Second Tuesday, February, May, August and November.

BROWN: William H. Bentson, M.D., President, 14 N. Second St., Ripley 45167; Jeffrey S. Donohoo, M.D., Secretary-Treasurer, 111 W. Cherry St., Georgetown 45121. Fourth Tuesday.

***BUTLER:** Ellen J. Buerk, M.D., President, 5141 Morning Sun Rd., Oxford 45056; Gerald S. Buerk, M.D., Secretary-Treasurer, 1017 Main St., Hamilton 45013; Frances L. Bachman, Executive Secretary, 111 Buckeye St., P.O. Box 3216, Hamilton 45013, 513/893-1410. Third Wednesday, October through May.

CLERMONT: Donald R. Williams, M.D., President, 473 Cincinnati-Batavia Pike, Cincinnati 45244; William B. Selnick, D.O., Secretary-Treasurer, Second & E. Loveland Aves., Loveland 45140. Third Wednesday except July and August.

CLINTON: Thomas M. Neville, M.D., President, 402 N. Beechgrove Rd., Wilmington 45177-9229; Bruce Staley, M.D., Secretary-Treasurer, 165 Silver Creek Dr., Wilmington 45177; Marilyn S. Walker, Executive Secretary, 119 Old Route 122, Lebanon 45036, 513/382-6611 (Lab). Fourth Tuesday except July, September and December.

***HAMILTON:** S. Marcus Wigser, M.D., President, 506 Oak St., Cincinnati 45219; Richard D. Riedel, M.D., Secretary, 3710 Paxton Ave., Cincinnati 45209; William J. Galligan, Executive Director, 320 Broadway, Cincinnati 45202, 513/421-7010. Second Tuesday except July and August.

HIGHLAND: No active county medical society.

WARREN: Gary P. Hayes, M.D., President, 1004 Oregonia Rd., Lebanon 45036-9740; Carl Durning, M.D., Secretary, 1618 Deerfield Rd., Lebanon 45036-9676. Second Tuesday.

SECOND DISTRICT

Councilor: *William J. Marshall, M.D.,* 2600 Far Hills Ave., Dayton 45419.

CHAMPAIGN: Ned Saini, M.D., President, 900 Scioto St., Urbana 43078-2226; Jae J. Koh, M.D., Secretary-Treasurer, 27 Rue St., Charles, Urbana 43078-2314. Second Wednesday, February, April, May, then as needed.

CLARK: Carl D. Hyde, M.D., President, Community Physicians of Yellow Springs, P.O. Box 241, Yellow Springs 45387-0241; Marios Panayides, M.D., Secretary, 444 W. Harding Rd., Springfield 45504-1793; Roberta Farish, Executive Secretary, 34 W. High St., Room 710, Springfield 45502, 513/324-8618. Third Monday.

DARKE: William H. Osterbur, M.D., President, 220 W. Martz St., Greenville 45331-1052; Donald W. Pohlman, M.D., Secretary, 8743 Cambridge Dr., Versailles 45380-9569. Third Tuesday.

GREENE: Justin G. Krause, D.O., President, 850 E. Xenia Dr., Fairborn 45324; Emerson Harewood, M.D., Secretary-Treasurer, P.O. Box 459, Xenia 45385-0459; Judy Khoii, Executive Director, 1141 N. Monroe Dr., Room 235, Xenia 45385, 513/376-3783. Second Wednesday, March, June, September and December.

***MIAMI:** Dean Allen Landes, M.D., President, 3130 N. Dixie Hwy., Troy 45373; Donald P. Luna, M.D., Secretary, Piqua Memorial Hospital, 624 Park Ave., Piqua 45356. First Tuesday, September through June.

MONTGOMERY: Walter A. Reiling, Jr., M.D., President, 2200 Philadelphia Dr., Suite 548, Dayton 45406-1830; G.S. Adebisi Adegbile, M.D., Secretary, 4001 Free Park, Dayton 45416-1233; Richard G. Tapia, Executive Director, 40 S. Perry St., #100, Dayton 45402, 513/223-0990. Fourth Thursday except July, August and December.

PREBLE: John D. Darrow, M.D., President and Secretary-Treasurer, 228 N. Barron St., Eaton 45320-1704.

SHELBY: Edward A. Link, M.D., President, Third & Michigan Sts., Sidney 45365; Robert V. Reinhold, M.D., Secretary-Treasurer, 915 W. Michigan St., Sidney 45365. Second Tuesday.

THIRD DISTRICT

Councilor: *Thomas R. Leech, M.D.,* 1700 W. Market St., Lima 45805.

***ALLEN:** Frank M. Baldauf, M.D., President, 658 W. Market St., #101, Lima 45801; Roger L. Terry, M.D., Secretary-Treasurer, 1220 E. Elm St., #110, Lima 45804; Will Wolf, Executive Secretary, P.O. Box 1647, Lima 45802, 419/228-3335. Third Tuesday, September through May.

AUGLAIZE: Robert P. Gill, M.D., President, 4 Eagle Dr., Minster 45865; Thomas C. Dozier, D.O., Secretary-Treasurer, 112 Court St., St. Marys 45885. First Thursday alternating months starting January.

CRAWFORD: James E. Loggins, M.D., President, 270 Portland Way S., Galion 44833; Kenneth M. Mondal, M.D., Secretary-Treasurer, 270 Portland Way S., Galion 44833-2311. Meetings when called.

HANCOCK: Jack G. Hendershot, Jr., M.D., President, 1920 S. Main St., Findlay 45840-1232; Mark A. Penn, M.D., Secretary, 104 N. Main St., Arlington 45814. Third Tuesday.

HARDIN: Leonard K. Smith, M.D., President, 900 E. Franklin St., Kenton 43326-2021; Jeffrey D. Lewis, M.D., Secretary-Treasurer, 13231 Route 309, Kenton 43326. Second Tuesday, September through April.

LOGAN: Evan W. Dixon, M.D., President, 212 Irving Ave., Bellefontaine 43311-2226; William K. Lehmann, M.D., Secretary-Treasurer, Mary Rutan Hospital, Bellefontaine 43311. Meetings when called.

***MARION:** David G. Bailey, M.D., President, 1132 Independence Ave., Marion 43302; Ronald A. Landefeld, M.D., Secretary-Treasurer, 170 Fairfax Ave., Marion 43302. First Tuesday.

MERCER: John Naveau, M.D., President, 407 S. Oak St., Coldwater 45828-1622; Mahmood Mir, M.D., Secretary-Treasurer, 123 Hamilton St., Celina 45822-1909. Third Thursday, September through May.

SENECA: Chong-Hyo Kim, M.D., President, 1309 W. Ridge Dr., Fostoria 44830; Randolph Gibbs, M.D., Secretary-Treasurer, 1315 Oxford Ln., Fostoria 44830-1644. Icil Bargaheiser, Executive Secretary, 423 S. Main St., Fostoria 44830, 419-435-5824. Third Tuesday, September through June except December.

VAN WERT: Joel D. Knerr, M.D., President, 290 E. Third St., Box 351, Ottoville 45876; Karl Miller, M.D., Secretary-Treasurer, 209 N. Main St., Rockford 45882. First Tuesday.

WYANDOT: Joseph J. Browne, M.D., President, 777 N. Sandusky Ave., Upper Sandusky 43351-1029; Herschel A. Rhodes, M.D., Secretary-Treasurer, 777 N. Sandusky Ave., Upper Sandusky 43351-1029; Robin Binkley, Executive Secretary, Wyandot Memorial Hospital, 885 N. Sandusky Ave., Upper Sandusky 43351, 419/294-4991. Second Tuesday.

FOURTH DISTRICT

Councilor: *John A. Devany, M.D.,* 2030 Mt. Vernon Blvd., Toledo 43607.

DEFIANCE: Paul E. Brose, M.D., President, 1400 E. Second St., Defiance 43512-2440; John J. Racciato, M.D., Secretary-Treasurer, 328 Koerber Dr., Defiance 43512-3318. First Saturday.

FULTON: David A. Thompson, M.D., President, 405 E. Lutz Rd., Archbold 43502-1252; Estela T. Miquiabas, M.D., Secretary-Treasurer, 725 S. Shoop Ave., Wauseon 43567-1701. Second Tuesday quarterly.

HENRY: Romeo S. Flora, M.D., President, 407 Independence Dr., Napoleon 43545-9678; Mary Jane Brand, M.D., Secretary-Treasurer, Henry County Hospital, 11-600 S.R. 424, Napoleon 43545-9399. Meetings when called.

LUCAS: Su-Pa Kang, M.D., President, 3900 Sunforest Court, Toledo 43623-4498; G. Mark Burton, M.D., Secretary, 4235 Secor Rd., Toledo 43623-4231; Lee F. Wealton, Executive Director, 4428 Secor Rd., Toledo 43623, 419/473-3200. Council fourth Tuesday, September through June.

OTTAWA: Robert W. Minick, M.D., President, 9849 W. S.R. 163, Oak Harbor 43449; Jeffrey F. Wirebaugh, M.D., Secretary-Treasurer, 1122 Lake St., Marblehead 43440-2034. Second Thursday during football season; otherwise, Friday after second Thursday; no summer meetings.

PAULDING: Kirkwood A. Pritchard, M.D., President, 119 S. Main St., Paulding 45879-1409; Don K. Snyder, M.D., Secretary-Treasurer, Box 57, Payne 45880-0057. Third Monday.

PUTNAM: Anna M. Horstman, M.D., President, Box 256, Kalida 45853-0256; David D. Houston, M.D., Secretary-Treasurer, 5560 S.R. 12, Box 299, Pandora 45877-0299. First Tuesday.

SANDUSKY: Mary E. Verdon, M.D., President, 605 Third Ave., Ste. B, Fremont 43420-3269; Patricia Lindholm, M.D., Secretary-Treasurer, 42 Glendale Ave., Fremont 43420. Third Wednesday.

WILLIAMS: Clarence A. Bell, Jr., M.D., President, 935 Snyder Ave., Montpelier 43543-1251; Richard L. Hess, M.D., Secretary-Treasurer, 442 W. High St., Bryan 43506-1616; Rebecca Cape, Executive Secretary, Bryan Medical Group, 442 W. High St., Bryan 43506, 419/636-4517 Monday, Wednesday, every other Friday. Third Tuesday, September, November, January, March and May.

***WOOD:** Albert W. Smith III, M.D., President, 640 S. Wintergarden Rd., Bowling Green 43402; Robert G. Neville, M.D., Secretary-Treasurer, 960 W.

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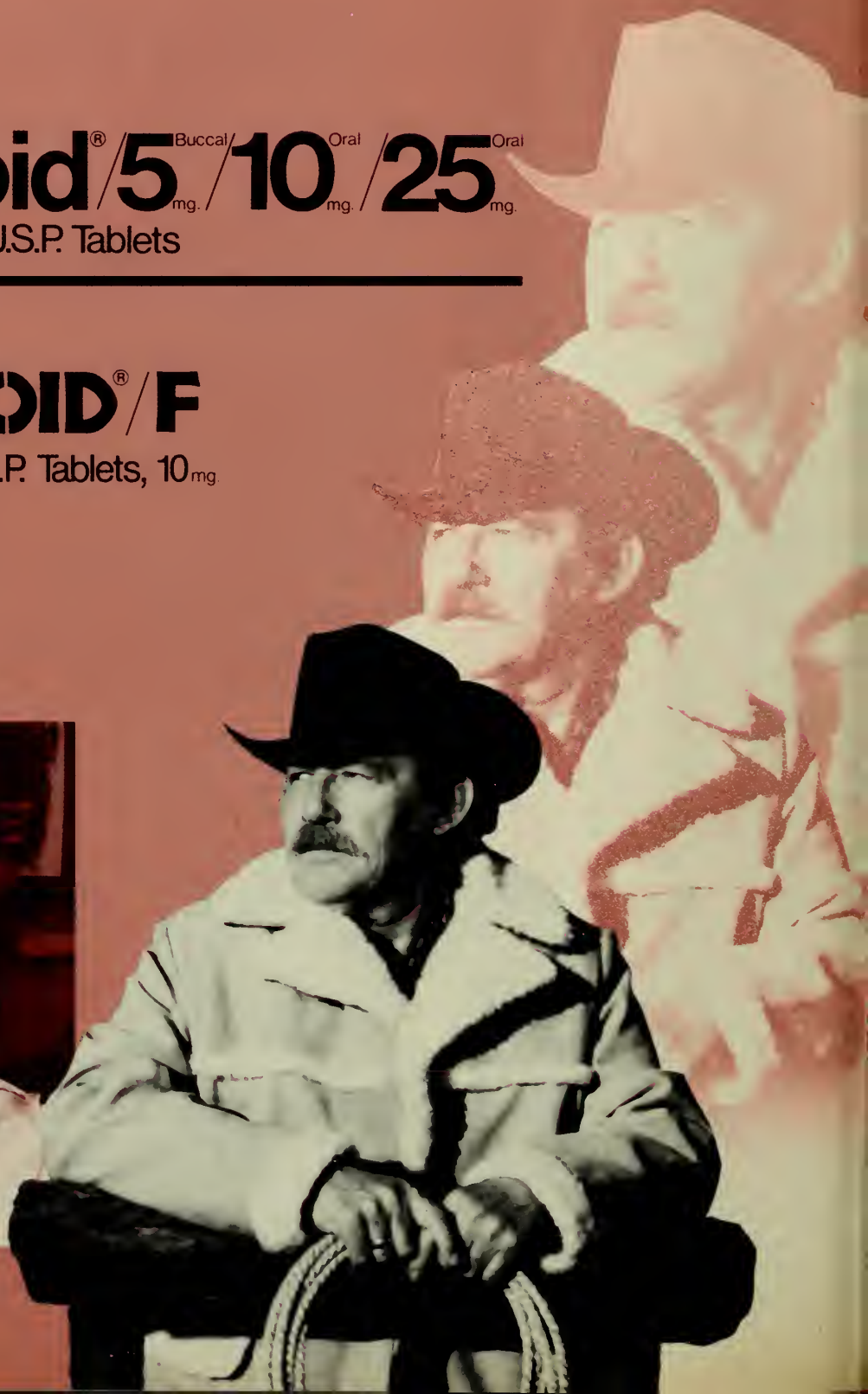
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Wooster St., Ste. 207, Bowling Green 43402. Second Thursday.

FIFTH DISTRICT

Councilor: *Donavin A. Baumgartner, Jr., M.D.,* St. Luke's Hospital E.R., 11311 Shaker Blvd., Cleveland 44104.

ASHTABULA: David A. Floering, M.D., President, 2470 Lake Ave., Ashtabula 44004-4954; Hector T. Abueg, M.D., Secretary-Treasurer, 244 Parrish Blvd., Conneaut 44030-2031; Amy Housel, Executive Secretary, P.O. Box 1772, Ashtabula 44004, 216/997-6640. Second Tuesday.

***CUYAHOGA:** Daniel A. Deutschman, M.D., President, 11201 Shaker Blvd., Cleveland 44104-3833, Attn. Carol Schwartz; O. David Solomon, M.D., Secretary-Treasurer, 26900 Cedar Rd., #310, Cleveland 44122; George D. Reitz, Executive Vice President, 11001 Cedar Ave., Cleveland 44106, 216/229-2200. Board of Directors second Tuesday.

GEAUGA: Donald Braunlich, D.O., President, 14493 N. Cheshire St., Burton 44021; Joan T. Davis, M.D., Secretary-Treasurer, 13221 Ravenna Rd., Chardon 44024; Margaret Pace, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024, 216/286-6131. Second Thursday, February, May/June, September and November.

LAKE: Jeffrey Siminovitch, M.D., President, 71 E. High St., Painesville 44077, Attn: Libby; Janet Blanchard, M.D., Secretary-Treasurer, 7923 Munson Rd., #9, Mentor 44060; Janice A. Vargo, Executive Secretary, 5900 Dewey Rd., Madison 44057, 216/942-9135. February, May, September and November.

SIXTH DISTRICT

Councilor: *J. James Anderson, M.D.,* 5204 Mahoning Ave., Ste. 103, Youngstown 44515.

COLUMBIANA: B. N. Bhat, M.D., President, 7941 S.R. 45, P.O. Box 369, Lisbon 44432-9324; Helouise Mapa, M.D., Secretary-Treasurer, 142 W. Fifth St., E. Liverpool 43920-2901; Pearl Koenreich, Executive Secretary, 530 Hawley Ave., Salem 44460, 216/337-8859. Third Tuesday, September through May except December.

MAHONING: G. Robert Barton, M.D., President, 447 Churchill Rd., Girard 44420-1938; Joseph W. Tandatnick, M.D., Secretary, St. Elizabeth Hospital, P.O. Box 1790, Youngstown 44501; Robert B. Blake, Executive Director, 1005 Belmont Ave., #245, Youngstown 44504, 216/747-4956. Third Tuesday, January, March, May, September, November and December.

STARK: Christopher M. King, M.D., President, 985 Sawburg Ave., N.E., Alliance 44601; Louis A. Kovacs, D.O., Secretary-Treasurer, 3140 Lincoln Way E., Ste. 200, Massillon 44646-3774; Nancy L. Adams, Executive Secretary, 4150 Belden Village St., N.W., Canton 44718, 216/492-3333. First Thursday, September through June.

TRUMBULL: Paul G. Zerbi, M.D., President, 3893 E. Market St., Warren 44484; Robert W. Taylor, M.D., Secretary-Treasurer, 1515 E. Market St., Warren 44483; Doris P. Dean, Executive Director, 280 N. Park Ave., Ste. 4, Warren 44481, 216/394-4556. Third Wednesday, September through May except December.

SEVENTH DISTRICT

Councilor: *Nermin D. Lavapies, M.D.,* 1220 Hughes Ave., Martins Ferry 43935-1935.

BELMONT: Wilmer G. Heceta, M.D., President, 3000 Guernsey St., Bellaire 43906-1540; Nermin D. Lavapies, M.D., Secretary-Treasurer, 1220 Hughes Ave., Martins Ferry 43935-1935. Third Tuesday, February through April and September through December.

CARROLL: Nan M. Bissell, M.D., President, 450 S. Lisbon St., Box 338, Carrollton 44615-0338; Donald P. Wingard, D.O., Secretary-Treasurer, P.O. Box 265, Carrollton 44615-0265. Third Tuesday.

COSHOCTON: Gary J. Carver, M.D., President, 904 Green Dr., Coshocton 43812-2454; Ronald W. Dillow, M.D., Secretary-Treasurer, 1849 Hillcrest Dr., Coshocton 43812-2729. Second Tuesday.

HARRISON: Ajit Modi, M.D., President, E. Market St., Cadiz 43907; Siripurapu R. Prasad, M.D., Secretary-Treasurer, Box 370, Hopedale 43976-0370. Second Tuesday.

JEFFERSON: Fernando L. Ayala, M.D., President, 1524 W. Market St., Steubenville 43952-1303; Augusto P. Fojas, M.D., Secretary-Treasurer, 4707 Scioto Dr., Steubenville 43952-3325. First Tuesday, August through May.

MONROE: Donald R. Piatt, M.D., President, 154 S. Main St., Woodsfield 43793-1023; Jack M. Matheny II, M.D., Secretary-Treasurer, Monroe County Clinic, Old Airport Rd., Rte. 3, Woodsfield 43793-9802. Second Wednesday quarterly.

TUSCARAWAS: Keith C. VanEpps, M.D., President, 216 W. Third St., P.O. Box 609, Dover 44622-2965; Donald R. Braden, M.D., Secretary-Treasurer, 420 Reeves Ave., Ste. B, Dover 44622-2162; Doris Ferguson, Executive Secretary, Union Hospital, 659 Blvd., Dover 44622, 216/343-3311. Second Wednesday.

EIGHTH DISTRICT

Councilor: *John F. Kroner, Jr., M.D.,* 444 W. Union St., Box 708, Athens 45701.

ATHENS: Muthia Shanmugham, M.D., President, O'Bleness Memorial Hospital, Hospital Dr., Athens 45701; John D. Cunningham, M.D., Secretary-Treasurer, 444 W. Union St., Athens 45701. Second Tuesday,

March, June, September and December.

FAIRFIELD: Paul Ruff, M.D., President, 125 N. Ewing St., Lancaster 43130-3309; John Lloyd, M.D., Secretary-Treasurer, 600 Pleasantville Rd., Lancaster 43130-3325; Jane E. Patterson, Executive Secretary, c/o David H. Sheidler, M.D., 1500 E. Main St., Lancaster 43130, 614/654-0059. Second Tuesday.

GUERNSEY: Jeffrey S. Moncman, M.D., President, 151 Merrick Rd., Cambridge 43725-9737; Stephen W. Stansbury, M.D., Secretary-Treasurer, 1337 N. Clark St., Box 357, Cambridge 43725-0357. First Tuesday alternating months starting with February.

LICKING: James L. Barrett, M.D., President, 131 N. Ewing St., Lancaster 43130-3309; David M. Jackson, M.D., Secretary-Treasurer, 155 McMillen Dr., Newark 43055-1810; Kitty Martin, Executive Secretary, Licking Memorial Hospital, 1320 W. Main St., Newark 43055, 614/366-0533. Fourth Tuesday.

MORGAN: No active county medical society.

MUSKINGUM: L. Joe Porter, M.D., President, 2634 Center Dr., Zanesville 43701-1425; Vicki Whitacre, M.D., Secretary-Treasurer, 2435 Dunzweiler Dr., Zanesville 43701-9624. First Tuesday.

NOBLE: Frederick M. Cox, M.D., President and Secretary-Treasurer, 523 Main St., P.O. Box 330, Caldwell 43724-1324.

PERRY: Stephen C. Ulrich, M.D., President, 1625 Airport Rd., P.O. Box 109, New Lexington 43764-0109; William D. Fiorini, M.D., Secretary-Treasurer, 313 North Dr., P.O. Box 430, Somerset 43783. Meet four times yearly.

WASHINGTON: David L. Wirtz, M.D., President, Dye St., P.O. Box 188, Newport 45768; Thomas L. Bryant, M.D., Secretary-Treasurer, 400 Mathew St., Marietta 45750-1634. Second Wednesday, September through May.

NINTH DISTRICT

Councilor: *Thomas P. Price, Jr., M.D.,* Chm., Dept. of Ob/Gyn, Holzer Clinic, Ltd., 385 Jackson Pike, Gallipolis 45631.

GALLIA: April B. Magnussen, M.D., President, Holzer Clinic, Ltd., 385 Jackson Pike, P.O. Box 344, Gallipolis 45631; James R. Magnussen, M.D., Secretary-Treasurer, Holzer Clinic, Ltd., 385 Jackson Pike, P.O. Box 344, Gallipolis 45631. Meet quarterly.

HOCKING: Rosario M. Labrador, M.D., President, P.O. Box 0920, Logan 43138; Jack R. Lawler, M.D., Secretary-Treasurer, P.O. Box 819, Logan 43138-0819. Meet three times yearly.

JACKSON: Patrick B. Ball, D.O., President, 350 Charlotte Ave., Oak Hill 45656-1326; Carl J. Greever, M.D., Secretary-Treasurer, 35 Vaughn St., Jackson 45640-1931. Meetings when called.

LAWRENCE: George M. Massoud, M.D., President, Sixth & Pine Sts., Ironton 45638; David A. Pack, M.D., Secretary-Treasurer, 1230 Navajo Trail, Ironton 45638-1752. Fourth Thursday.

MEIGS: E.S. Villanueva, M.D., President, 505 Mulberry Heights, Pomeroy 45769-9573; Wilma A. Mansfield, M.D., Secretary-Treasurer, P.O. Box 351, Pomeroy 45769-0351. Meetings when called.

PIKE: Kenneth A. Wilkinson, M.D., President, 100 Hilltop Rd., Waverly 45690; R. Bruce McClure, D.O., Secretary-Treasurer, 227 Valleyview Dr., Waverly 45690. Second Monday.

SCIOTO: George E. Esham, M.D., President, 1711 — 27th St., Portsmouth 45662-2638; Wayne E. Young, M.D., Secretary-Treasurer, 2125 Sandstone Dr., Portsmouth 45662; Ann Borden, Executive Secretary, 1805 — 27th St., Portsmouth 45662-2640, 614/354-5315. Second Tuesday, September through June, except December and February meetings are second Thursday.

VINTON: No active county medical society.

TENTH DISTRICT

Councilor: *H. William Porterfield, M.D.,* 3580 Hythe Court, Columbus 43220.

DELAWARE: Judith K. Held, M.D., President, 695 W. Central Ave., Delaware 43015-1409; Lloyd E. Moore, M.D., Secretary-Treasurer, 141 S. Main St., Prospect 43342-9569. Third Tuesday, March, June, September and December.

FAYETTE: Byers W. Shaw, M.D., President, 616 Willard St., Washington C.H. 43160-2161; Robert A. Heiny, M.D., Secretary, 616 Willard St., P.O. Box 457, Washington C.H. 43160-0457. Second Friday.

***FRANKLIN:** William A. Millhon, M.D., President, 3730 Olentangy River Rd., Columbus 43214; Ronald E. Kendrick, M.D., Secretary-Treasurer, 911 Stoney Creek Rd., Worthington 43085; James S. Imboden, Executive Director, 525 Metro Place N., Ste. 440, Dublin 43017, 614/766-6221. February, August, September and October.

***KNOX:** James J. Wanken, M.D., President, P.O. Box 591, Mt. Vernon 43050; Raymond E. Hatton, M.D., Secretary-Treasurer, 5 N. Gay St., #200, Mt. Vernon 43050. First Wednesday.

MADISON: William C. Locke, D.O., President, 214 E. Elm St., London 43140-1184; Mark A. Coate, M.D., Secretary-Treasurer, 214 Elm St., London 43140. Second Wednesday.

MORROW: Brian L. Bachelder, M.D., President, 661 W. Marion Rd., Mt. Gilead 43338-1027; William K. Lee, M.D., Secretary-Treasurer, 117 E. Main St.,

Cardington 43315-1115. First Tuesday.

PICKAWAY: Jeffrey W. Milks, M.D., President, 210 Sylvan Cir., Circleville 43113; Gary L. Gillen, M.D., Secretary-Treasurer, 111 Island Rd., Circleville 43113. Second Tuesday.

ROSS: Joseph C. Bennett, M.D., President, 65 Timberlane Dr., Chillicothe 45601-1939; Richard C. Rooney, M.D., Secretary-Treasurer, P.O. Box 904, Station A, Chillicothe 45601. First Thursday.

UNION: Mary Pedersen, M.D., President, 103 Church St., Plain City 43064-1230; Brian E. Higgins, D.O., Secretary-Treasurer, 498 London Ave., Marysville 43040. First or third Tuesday.

ELEVENTH DISTRICT

Councilor: *Charles G. Adams, M.D.,* 5896 Liberty Ave., Vermilion 44089.

ASHLAND: Jon H. Cooperrider, M.D., President, 637 N. Union St., Loudonville 44842; Arvind K. Malhotra, M.D., Secretary-Treasurer, 1363 Hillcrest Dr., Ashland 44805-4431. First Tuesday.

ERIE: Donald W. Lenhart, M.D., President, 1221 Hayes Ave., Sandusky 44870-3345; James R. Berry, M.D., Secretary, 1815 Milan Rd., Sandusky 44870-4102; Barbara Wolfert, Executive Secretary, 2710 Scheid Rd., Huron 44839, 419/433-3097. Second Tuesday.

HOLMES: Maurice E. Mullet, M.D., President, W. Main St., Berlin 44610; Daniel J. Miller, M.D., Secretary-Treasurer, P.O. Box 143, Walnut Creek 44687-0143. Second Monday.

HURON: Thomas H. Eaton, M.D., President, 813 Northwest St., Bellevue 44811; Pura Garin-Vargas, M.D., Secretary-Treasurer, 38 Executive Dr., Norwalk 44857. Second Wednesday, February, April, June, October and December.

LORAIN: Kenneth J. Bescak, President, 3600 Kolbe Rd., #105, Lorain 44053-1691; Carl M. Yood, M.D., Secretary-Treasurer, 3600 Kolbe Rd., #205-A, Lorain 44053-1691; Shirley Dalton, Executive Secretary, 1875 N. Ridge Rd. E., Ste. E, Lorain 44055, 216/277-9009. Second Tuesday.

MEDINA: Thomas D. Bica, M.D., President, 970 E. Washington St., Medina 44256; William D. Smucker, M.D., Secretary-Treasurer, 970 E. Washington St., #401, Medina 44256; John E. Gerding, Executive Secretary, 3377 Forest Hills Dr., Medina 44256, 216/725-5331. Third Thursday, October through May except December.

RICHLAND: Robert A. Struble, M.D., President, 1221 Trimble S., Mansfield 44907-2229; Paul D. Kautz, M.D., Secretary-Treasurer, 370 Cline Ave., Mansfield 44907-1022; Frances V. Cash, Executive Secretary, 295 Glessner Ave., Mansfield 44903, 419/526-8799. Third Thursday.

WAYNE: George H. Kuffner, M.D., President, 1740 Cleveland Rd., Wooster 44691-2296; Daniel E. Stump, M.D., Secretary-Treasurer, 1761 Beall Ave., Wooster 44691-2342. Meetings when called.

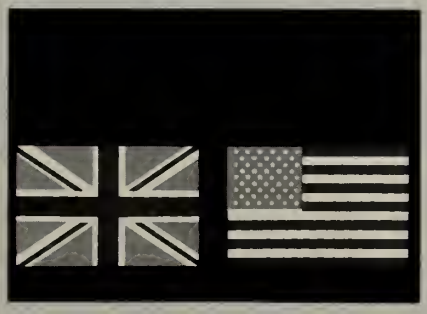
TWELFTH DISTRICT

Councilor: *Joseph L. Kloss, M.D.,* 737 Ridgecrest Rd., Akron 43303.

PORTAGE: Michael Mastromatteo, M.D., President, 303 N. Chestnut St., Ravenna 44266-2215; Atila N. Can, M.D., Secretary-Treasurer, 202 E. Summit St., Kent 44240-3650. Second Tuesday.

SUMMIT: Charles A. Peter, M.D., President, 656 W. Market St., Akron 44303-1441; Jack L. Summers, M.D., Secretary, 266 Indian Hills Dr., Tallmadge 44278-2955; Shirley Bee, Managing Director, 430 Grant St., Akron 44311, 216/434-1921. First Tuesday, January, March, May, September and November.

Continuing Medical Education



NEURO-RADIOLOGY UPDATE — OHIO STATE RADIOLOGICAL SOCIETY ANNUAL MEETING: May 9-10; Dayton Marriott Hotel; sponsor: Ohio State Radiological Society; joint sponsor: Ohio State Medical Association; 8½ credit hours; no fee to members, $100 for non-members; contact: Connie Diaz, Ohio State Radiological Society, 600 South High Street, Columbus 43215, phone: 614/228-6971.

THE FUTURE OF COMPUTERS IN PRIMARY CARE — AN ANGLO-AMERICAN CONFERENCE: May 13-15, 1987; University of Cincinnati Medical Center; sponsor: University of Cincinnati Medical Center; 16 credit hours; fee: $325; contact: John R. Kues, Ph.D., Dept. of Family Medicine, 231 Bethesda Ave., Cincinnati 45267, phone: 513/872-4066.

UPDATE ON PRACTICAL APPROACH TO INFECTIOUS DISEASES: May 14; Holiday Inn, Troy; sponsor: Dettmer Hospital; joint sponsor: Wright State University School of Medicine; 7 credit hours; fee: $60, $30 for non-physicians and physicians in training; contact: Gerard F. Wolf, M.D., 145 Sunset Drive, Piqua 45356, phone: 513/773-8323.

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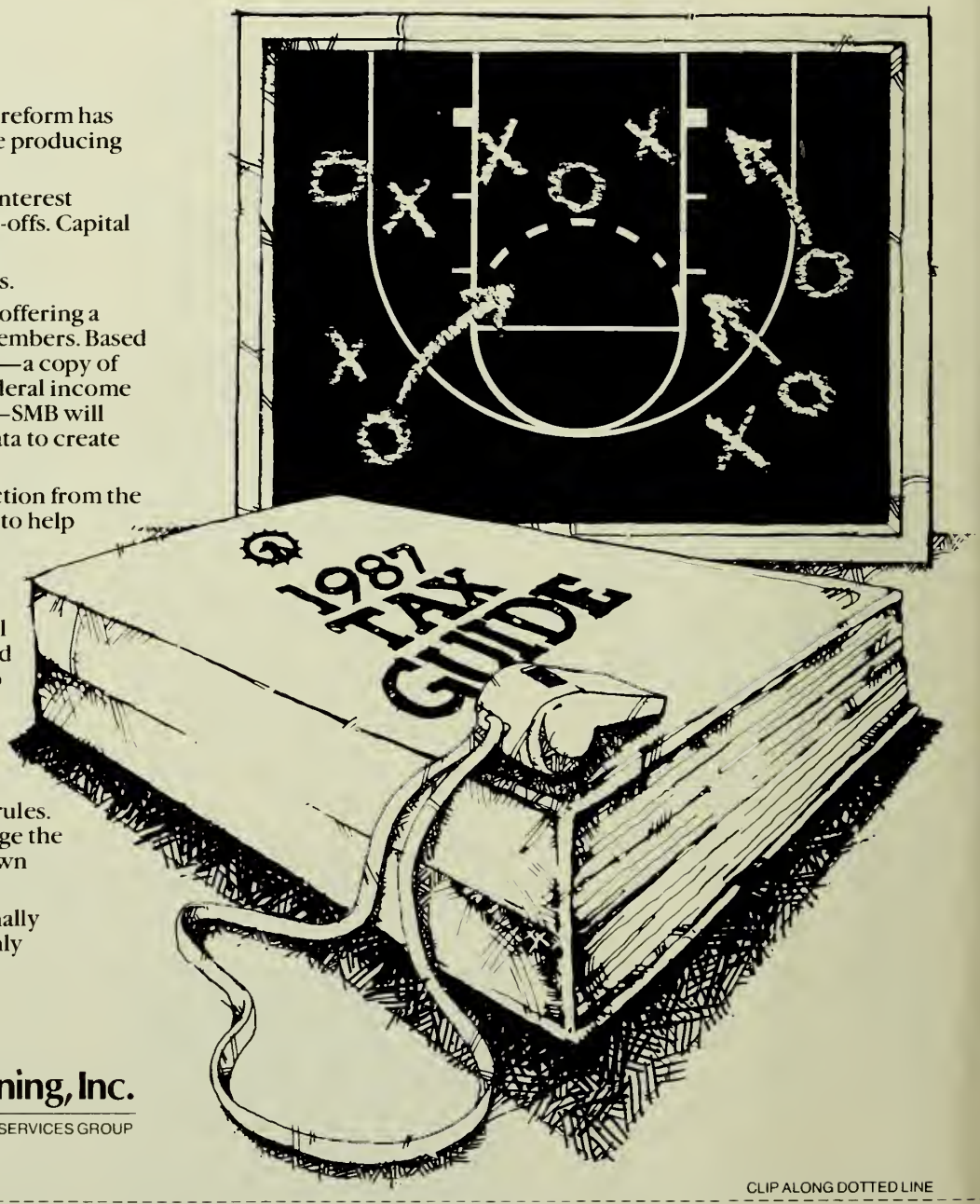
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When Your Patients Ask You Questions About AIDS

By Susan Porter

He's seen the proliferation of reports in the newspapers and on the nightly news. He's afraid a guy he works with on the assembly line may have the disease. Can he catch it by working next to him?

Since her divorce five years ago, she's had relationships with a lot of different men. Has she been exposed to the virus?

He's having surgery next week, and he's worried about the possibility of transfusions. Might he get contaminated blood?

She's getting married in June. Should she ask her fiance to be tested?

The above are just a sampling of the barrage of questions Ohio patients are now asking their physicians about AIDS. And it's hard to believe that the concerns they express would not have existed five years ago. Had the word *aids* come up at all in the health care setting, it would have been used in a positive manner — to describe people or items that enhance a patient's opportunity for recovery, not a dreaded condition which leaves patients open to all sorts of opportunistic infections. Not until 1981 did the terms AIDS become an acronym for the mysterious condition known as acquired immune deficiency syndrome. Since that time, more than the connotation of the word has changed.

Today, AIDS has the potential of becoming the greatest public health care problem of the late 20th century. By 1991, says a recent Public Health Service Report, AIDS cases will reach 270,000 nationwide, resulting in an estimated 179,000 deaths — making it one of the country's top 10 killers. Medical costs for AIDS patients will soar to between $8 billion and $16 billion that year, representing up to 2.4% of the nation's health care dollar.

If AIDS continues to go unchecked, according to U.S. Surgeon General C. Everett Koop, MD, in a recent article in *USA Today,* it could kill 100 million people worldwide by the year 2000. "AIDS is a life-threatening disease and a major public health issue," says Dr. Koop in his newly issued Surgeon General's Report on AIDS. "Its impact on society is and will continue to be devastating."

Ohio physicians who work closely with the problem are equally alarmed. "I've been working in the AIDS area since 1982," says Michael Lederman, MD, an AIDS researcher and immunologist at Case Western Reserve University, who also treats AIDS patients in the Cleveland area, "and I can't tell you how pessimistic I am. This is the worst medical disaster we've seen in the past quarter century. It has the potential to wipe out substantial proportions of our population and our next generation."

Dr. Lederman and his colleagues were among the first to report the heterosexual transmission of the AIDS virus from a male hemophiliac patient to his female sexual partner. It is important that AIDS be viewed as a lethal sexually transmitted disease that could infect large numbers of men and women in this country, says Dr. Lederman, pointing out too many still regard it as a condition limited to the homosexual

"We estimate that anywhere from 30,000 to 40,000 Ohioans are now infected with the AIDS virus."

community. "If we wait until we see large numbers of heterosexual patients infected," he says, "it will be too late."

Only 304 cases of AIDS had been reported in the state of Ohio as of January 1, 1987, according to Thomas Halpin, MD, acting director of the Ohio Department of Health. Still, that is double the number of cases seen in this state a year ago, and the numbers are growing at an alarming rate. "We estimate that anywhere from 30,000 to 40,000 Ohioans are now infected with the AIDS virus," says Dr. Halpin. "A conservative estimate is that of that group, 10% to 30% will end up with full-blown AIDS within the next three to five years. And AIDS is just the tip of the iceberg."

The presence of HIV antibodies in blood has also shown to precede a number of other chronic conditions, including AIDS Related Complex (ARC), which debilitates patients but does not always end in AIDS or death. "On top of that, we are now seeing a new form of dementia associated with the AIDS virus," says Dr. Halpin. "An individual may not develop the full-blown AIDS or ARC — but he or she may suffer from other problems."

Dr. Lederman points out that because AIDS is such a new phenomenon and has a long incubation period, the long-term ramifications of the virus have yet to be discovered. "It could be that in 10 years, 50% of those infected with the virus may eventually come down with AIDS," he says. "And who knows what happens after someone has had the virus in their brain for 20 years — if anyone survives that long."

Equally alarming is the fact that those infected continue to spread the virus, says Dr. Halpin, so that the 30,000 to 40,000 figure could mushroom before the turn of the century. "AIDS is a problem for all sexually active people, along with anyone who might be tempted at some point in time to experiment with drugs using an IV needle," says Dr. Halpin, adding that the nation's youth are particularly prone to the reckless and promiscuous forms of behavior that could lead to AIDS.

The good news, however, is that "AIDS is preventable," says the Surgeon General's report. "It can be controlled by changes in personal behavior. It is the responsibility of every citizen to be informed about AIDS and to exercise the appropriate preventive measures."

Despite a great deal of public and professional attention now being given to the problem, a lot of misunderstanding exists about AIDS in the public-at-large. Ironically, the more AIDS is

RISK GROUPS FOR AIDS IN OHIO

Group	Total Cases	Percentage
Gay/Bisexual Males	219	72%
IV Drug Users	16	5%
Gay & Drugs	30	10%
Hemophilia	14	5%
Heterosexual Contact	6	2%
Blood Products	8	3%
Other	11	3%

TOTAL NUMBER OF AIDS CASES IN OHIO — BY COUNTY

As of January 22, 1987

County	AIDS Diagnoses	Deaths
1. Cuyahoga	88	52
2. Franklin	54	33
3. Hamilton	25	19
4. Montgomery	21	12
5. Stark	10	8
6. Summit	9	5
7. Lucas	8	3
8. Clark	8	5
9. Lorain	7	4
10. Mahoning	5	3
11. Lake	5	4
12. Other	64	40
TOTAL	**304**	**188**

"This is a coastal phenomenon that is moving in on us from both directions . . . we need to prepare for it or we, too, will suffer the full impact."

covered in newspapers, magazines and TV, the more questions people seem to have about the disease, says Lois Hall, surveillance coordinator of the AIDS Activities Unit, the Ohio Department of Health.

"A new piece of news about AIDS comes out in the media," says Hall, "and it leaves people wondering about how it affects them." Too often, she says, their questions go unanswered, leaving rumor and hearsay to fill the gap where factual, accurate information is needed.

This is the chief reason why May 11-17 has been declared AIDS Awareness Week by the Ohio Department of Health, which will sponsor an all-out campaign to provide factual information on AIDS to all Ohioans. (See related story.) Also targeted in AIDS Awareness Week are Ohio physicians who may be up-to-date on facts and figures, but who still "are not well-prepared to deal with AIDS in their offices, as well as with the emotional turmoil their patients may experience," says Hall.

Such turmoil is not limited to those infected with the AIDS virus, or even to those who have good reason to believe they may have been exposed to AIDS. While those in the high-risk groups — male homosexuals and bisexuals, intravenous drug users, those who have received contaminated blood transfusions and those who have had heterosexual contacts with infected partners — may have reason for concern, others worry unnecessarily or fear they will contact the infection through casual contact, such as the case of the assemblyman working next to a possible AIDS victim in a factory.

Physicians who see patients who are worried without reason need to be able to allay their fears, says Hall, and to help them separate the facts from the myths. This will help to eliminate the AIDS hysteria which, in some cases, has proven as psychologically and socially damaging as AIDS itself, she says.

On the other hand, she adds, "Physicians need to be a little more pro-active" when it comes to warning unconcerned patients about the possibility of AIDS infection. "If you're seeing someone who is 22 years old and is sexually active with multiple partners, you need to let him or her know the facts about AIDS," says Hall. Frequently, this means "prying" into a patient's sexual history or practices — or explaining in graphic terms how to avoid being exposed through sexual encounters. Not all physicians are comfortable talking about these subjects, says Hall, yet such open, forthright communication is essential if the spread of AIDS is to be curtailed.

Dr. Lederman believes that "a part of every physician's talk with every patient who is of an age where sexual activity or drug abuse is a possibility should include information about AIDS. This is a horrible thing to have to bring up with your patients," he says. "But it has to be done. It is more important than all of the research we are doing."

Unfortunately, says Dr. Lederman and other researchers around the state, progress is painstakingly slow in the fight against AIDS in the laboratory. This is why it is essential that drastic measures be taken at once to curtail its spread. "Part of our responsibility as physicians is to initiate preventive measures — to protect our patients from the spread of an illness and to prevent their likelihood of contact," he says.

Dr. Lederman's research accomplishments in the area of AIDS have been noteworthy, as have those of others in the state. Oscar Ratnoff, MD, also at Case Western, for instance, was among the first to link AIDS to an immunodeficiency he was observing in hemophilia patients. Once the virus was identified, he went back and examined 460 sera samples collected from patients between 1965 and 1984, finding no antibody to the AIDS virus from samples taken before 1980. This work helped support the theory that AIDS did not exist in this risk group prior to this time.

Today, he and Dr. Lederman continue to examine the impact of

HOW OHIO RANKS WITH AIDS VICTIMS

(Including the District of Columbia and Puerto Rico)

Residence by State	Cases
1. New York	9281
2. California	6394
3. Florida	1914
4. Texas	1791
5. New Jersey	1728
6. Illinois	715
7. Pennsylvania	649
8. Massachusetts	577
9. Georgia	576
10. District of Columbia	521
11. Ohio	304
TOTAL U.S.	**29,137**

U.S. fatalities 16,481/29,137 (57%)
Ohio fatalities 188/304 (62%)

"We need to find out how much (AIDS) does cost so we can begin to examine our options and expand medical programs if necessary."

the AIDS virus on human cells. Other research on AIDS being conducted around the state and country focuses on ways to restore an infected patient's immune system, as well as on the development of new drugs and therapies to fight off the opportunistic infections that eventually claim the AIDS patient.

Peter Walzer, MD, of the VA Medical Center in Cincinnati, is involved in work in the last category. His research for the past 15 years has surrounded pneumocystis carinii pneumonia — one of the major opportunistic infections that now kills victims of AIDS — along with the development of a drug to fight the condition. "We've discovered a number of new agents that seem quite promising in laboratory animals," he relates.

Still, a drug or vaccine that can be used effectively on humans may be years away, he and others relate — despite some short-term success with azidothymidine (AZT), a new experimental drug that inhibits the HIV's ability to produce new virus particles. Michael Para, MD, of the Ohio State University Hospitals in Columbus, is one of a number of physicians around the state using AZT on some AIDS patients with some success. (Only AIDS patients who have recovered from a first bout of pneumocystis carinii infection are eligible to receive treatment with AZT.)

"Most patients feel better after taking the drug," he says. "They gain weight, their immune systems improve and their number of lymphocytes increase," he says. However, it does have side effects, he adds, similar to those of patients on chemotherapy. Because the drug has been used in this manner for such a short time, its long-term benefits and/or dangers are still unknown. Thus, he and most others agree that AZT is not the long-awaited answer to the AIDS problem.

In fact, as Lois Hall points out, AZT and other temporary remedies only prolong the agony in many cases. Thus, the state's major thrust continues to be education and prevention — particularly since Ohio's current AIDS population is not large enough to attract major research grants.

"Ohio currently has 5% of the nation's population, yet only 1% of the cases of AIDS," Hall explains. Of 50 states, Ohio ranks 16th in the number of AIDS cases reported to date. "Yet this is a coastal phenomenon that is moving in on us from both directions," she says. "Therefore, we need to be prepared for it — or we, too, will suffer the full impact."

At present, says Hall, the bulk of the nearly $1 million budget of the Ohio Department of Health's AIDS Activity Unit goes to the state's seven Education, Testing and Counseling Sites, where some 8,000 Ohioans have been tested anonymously for the HIV antibody. (Approximately $800,000

AIDS Discrimination Task Force

As a medical and social issue, AIDS has stretched the limits of our society's ability to deal with the problem. As researchers continue to search for a cure for this deadly disease, it has become imperative to examine the impact of AIDS on society.

At the 1986 OSMA House of Delegates Meeting, two resolutions were submitted regarding the social implications of AIDS. One resolution, 26-86, asked the OSMA to draft and seek a sponsor for legislation which would make it illegal to discriminate in any fashion against any individual with a positive HTLV-III/BLOT Test. The other resolution, 27-86, asked the OSMA to support and actively participate in the formation and adoption of a formal policy stating its position concerning infection of a medical student, resident or staff health care professional with HTLV-III, creating guidelines which would deal with the fact that these persons may be both potential donors and victims of HTLV via patient contact.

The House of Delegates, recognizing the complexity of these resolutions, referred them to the OSMA Council for action. Council, in turn, created a special Task Force on Aids Discrimination to address the two resolutions.

E. Huxley Miller, MD, Cincinnati, serves as Chairman of this Task Force. Other members are: Joan Wurmbrand, MD, Gahanna; Jack Summers, MD, Tallmadge; James B. Metzger, MD, Toledo; Stanley L. Fox, MD, Cleveland; George Nankervis, MD, Akron; and Thomas Halpin, MD, Acting Director of the Ohio Department of Health, Columbus.

This Task Force will report back to Council in the near future with its recommendations regarding the two resolutions. — *Carol Wright Mullinax*

"Our goal is to have a highly educated population of physicians willing and able to discuss the AIDS problem with their patients."

of the AIDS budget is federally funded. Only $200,000 comes from state funds.)

Formerly known as Alternative Testing Sites, the nature of these centers has changed, Hall explains. "Today we place more emphasis on education and counseling," says Hall. Because high-risk individuals are those most likely to seek out the test, it presents a prime opportunity to inform these individuals about AIDS in a one-on-one educational session. Those who test positive to the antibody test require even more attention and counseling, she adds, including information on their chances of developing AIDS and other complications, along with how to protect future partners from becoming infected.

Currently, AIDS Education, Testing and Counseling Sites are located in Cleveland, Columbus, Cincinnati, Akron, Toledo, Dayton and Youngstown. According to Bob Campbell, Supervisor of the AIDS Activity Unit and an epidemiologist with the Ohio Department of Health, new sites will open in Lima, Athens, Portsmouth, Mansfield, Painesville and Zanesville in the near future.

The Ohio Department of Health also is in the process of updating its comprehensive resource directory, which lists the names of physicians, hospitals, dentists, blood banks, mental health workers, clergy, support groups, medical suppliers and others willing and able to aid AIDS patients. The AIDS Advisory Unit — less than one year old — has also provided all local health departments and every hospital infectious control department with a comprehensive AIDS Information Manual, containing all pertinent information currently known about the AIDS virus, from transmission to treatment.

Another project currently underway is a study of the cost of treating AIDS patients in Ohio. The Department of Health is working with a major hospital in each of Ohio's three largest cities to track these costs and to predict the financial impact AIDS could have on future health care dollars in Ohio. "We've been told it costs an average of $140,000 to treat an AIDS patient," says Hall, "and we've also heard figures as low as $30,000. We need to find out exactly how much it does cost, so that we can begin to examine our options and to expand medical programs, if necessary."

Those who staff the AIDS Unit also spend a great deal of time consulting with individuals and groups around the state who are dealing with the AIDS issue, including school systems attempting to set up policies related to AIDS and other infectious diseases and local AIDS task forces dealing with the problem in their communities. The unit works under the guidance of a special AIDS Advisory Committee, comprised of physicians and other health care workers from around the state.

The bulk of that committee's attention also has focused on education and prevention. Still, this is a task that may be easier said than done, at least one committee member has discovered.

Leonard Calabrese, DO, is currently involved in a research project at the Cleveland Clinic Foundation, Inc., which attempts to assess the impact of AIDS education on high-risk groups. The study looks at a number of variables, including education level and other demographics to see how they impact sexual practices and precautionary measures taken by certain individuals. Some 303 homosexual males in northeast Ohio were surveyed about their recent sexual practices, as well as their backgrounds and sources of information on AIDS. The results were disturbing.

A full 71% were "persisting in some activities that have been clearly described as unsafe," Dr. Calabrese reports. Variables, including educational level and knowledge about safe sexual practices, appeared to have little impact on an individual's willingness to take the proper precautions.

"Obviously, this is a complicated problem and will require much more effort than simply playing some condom commercials or encouraging individuals to have safe sex," says Dr. Calabrese. Currently, the researchers are looking at psychological factors, such as levels of stress, depression and anxiety, that might prove better indicators of an individual's propensity toward taking risks — as well as provide some insights on how to change their risk-taking behaviors.

Dr. Calabrese is also among believers that physicians can have a great impact on their patients' attitudes, as well as their health and safety. He is currently involved with the Cleveland Academy of Medicine in producing an AIDS education program aimed directly at practicing physicians, emphasizing the preventative and public health aspects of AIDS. The educational video, which will be completed this spring, "will emphasize physicians' ability to incorporate meaningful information about AIDS into their practices," says Dr. Calabrese. The

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The Ohio Heart and Vascular Institute at Mount Carmel

Cleveland Academy will simultaneously sponsor a public education campaign, encouraging patients to go to their doctors for accurate information and advice about AIDS.

"Our goal is to have a highly educated population of physicians willing and able to discuss the AIDS problem with their patients, and a population of patients not afraid to bring it up to their physicians," says Dr. Calabrese. "Right now, patients are embarrassed and physicians are uncomfortable. The area is moving so fast that it's easy to feel out of date."

Yet it is essential, says Dr. Lederman, that physicians in all specialties stay informed. "Read journals, attend lectures and be as informed on this issue as you can be," he advises. "Physicians need to be advocates for public education and to demand that their communities provide public education on AIDS through the schools and the media," he adds.

Until very recently, says Dr. Para, many physicians remained unconcerned about the AIDS problem, viewing it largely as a big-city coastal problem affecting only homosexuals and drug users. In one Ohio community, he relates, some physicians actually protested having an AIDS presentation at their county medical society meeting, feeling it was an inappropriate topic for discussion.

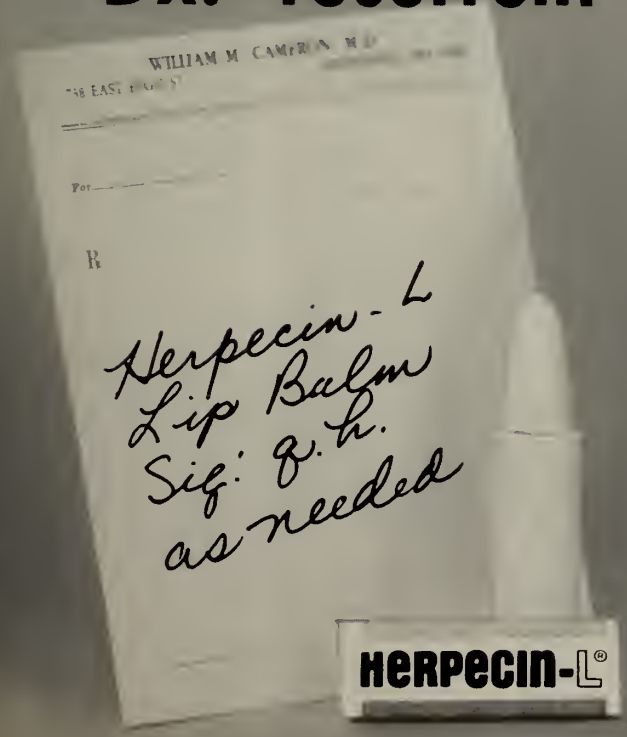
Today, however, "we get a lot more requests for presentations at all levels," he says. One reason is that many more physicians are being asked questions by their patients that they're not sure how to answer. And the days for questions-only are numbered, he and others believe, pointing out that literally every county in the state has had at least one reported case of AIDS, while the problem can only get worse.

"Two weeks ago," says Dr. Para, "a general practitioner was among a group who heard our presentation on AIDS. He said at the time, he thought he'd never see a case in his practice. But a week later, he was calling us with a patient who had all of the symptoms." **OSMA**

Susan Porter is the Associate Editor of **Ohio Medicine.**

See related AIDS story, next page.

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What To Tell Your Patients About AIDS

AIDS is a complex syndrome that continues to stump those physicians, researchers and scientists working closest to it; thus, it is little wonder that patients frequently lack information or are misinformed about its origin, transmission, symptoms, treatment and consequences. However, a number of facts about the transmission — and prevention — of AIDS are known and should be included in any discussion you might have about AIDS with a patient. These include:

- AIDS is not transmitted through casual contacts (eg. shaking hands, sitting next to an infected person, eating food prepared by an AIDS patient, etc.) Rather, it is passed through specific acts with an infected person which result in the exchange of contaminated body fluids: semen, blood, vaginal secretions, feces or urine. The most common means are "high-risk" sexual activities with an infected partner — those activities violent enough to open up a blood channel, either through mucous membrane or broken skin — or sharing needles with an infected person.
- Sexual activities that put individuals at risk of AIDS are oral-penile, oral-anal, anal-penile, oral-vaginal and penile-vaginal contacts with an infected person. AIDS is most often transmitted through anal intercourse, a practice that can tear the delicate lining of the rectum and allow the virus to enter the body's circulatory system. The use of contraceptive measures (condoms) that could prevent entry of a virus into the bloodstream and also could kill it (spermicides) are recommended to prevent transmission.
- The virus can be passed both from men to women and from women to men, as well as from men to men. It is essential that patients know the sexual background and habits of partners. Reduction in the number of sexual encounters also reduces chance of infection, although having high-risk sex with even one infected partner one time can result in transmission of the virus.
- Avoid all sexual contacts with persons who use unprescribed IV drugs. Do not share or re-use needles, syringes, preparation vials or unprescribed intravenous drugs.
- The screening of blood donors for evidence of HIV infection and the appropriate treatment of blood products have greatly reduced the chances of contracting the AIDS virus through blood transfusion. Because blood banks and other collection centers use sterile equipment and disposable needles, there is no chance that a needle used for a blood donor would be used by another donor. Therefore, there is no danger of contracting AIDS from donating blood.
- Infection with the HIV virus does not invariably lead to AIDS — AIDS is the most extreme and severe manifestation of infection with HIV. Preliminary studies show many infected individuals remain in good health. However, IT IS IMPORTANT TO KNOW THAT EVEN IF INFECTED PERSONS REMAIN WELL, THEY MAY TRANSMIT THE VIRUS TO OTHERS, who may then become ill.
- Infected persons have an ethical obligation to inform sexual partners of their status. They should also inform health care providers, including dentists, of their serological and high-risk status, so that appropriate blood and body fluid precautions can be taken when providing patient care.
- Evaluations of health workers caring for persons with AIDS and persons living in households with AIDS patients have consistently shown no evidence of risk of spread by an airborne route or non-sexual casual contact. Living in the same house as an infected person, caring for an AIDS patient, eating food handled by a person with AIDS, being coughed or sneezed upon by an infected person, casual kissing or swimming in a pool with an infected person do not cause AIDS. However, HIV-infected persons are advised not to share personal items, such as razor blades or toothbrushes, and those coming into frequent contact with blood and body products of an infected person should wear gloves and take other precautions.
- High-risk individuals who fear they may be infected by the HIV can take advantage of free and anonymous testing and

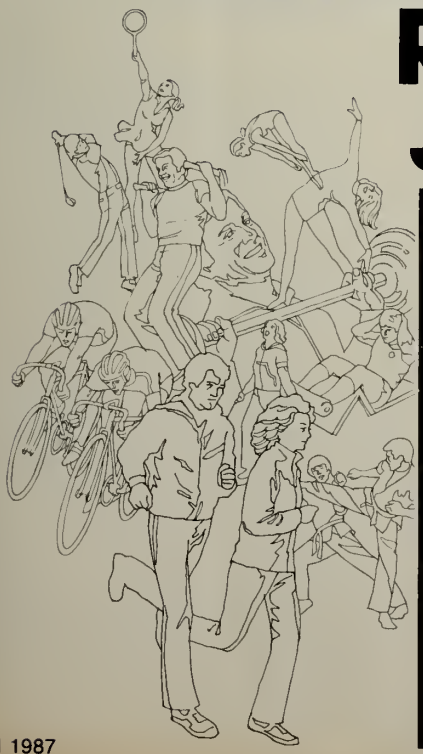
High-risk individuals who fear they may be infected can take advantage of free, anonymous tests at seven sites around the state.

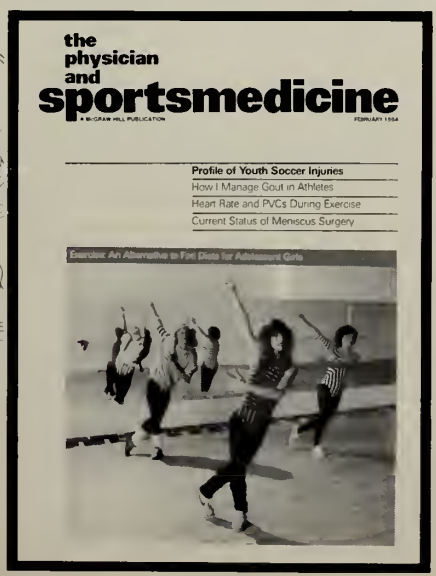
counseling at seven sites around the state. The test detects evidence of infection with the AIDS virus — however, it does not mean the individual will come down with the full-blown AIDS syndrome. For the nearest location or professional referral, call the AIDS Hotline at 1-800-332-AIDS.

- Most individuals infected with HIV have no symptoms, feel well and engage in their usual activities, even though the virus is present in their blood. Some develop symptoms which may include fatigue, fever, loss of appetite and weight, diarrhea, night sweats and lymph gland enlargement. This group of symptoms is sometimes referred to as AIDS-related complex (ARC). Some ARC patients go on to develop impaired immune defenses which leave them open to opportunistic infections. The most common of these infections are pneumocystis carinii pneumonia (PCP), a parasite infection of the lungs; and Kaposi's sarcoma, a type of cancer. It is these infections that ultimately will claim the life of the AIDS patient.
- While research to discover a vaccine or cure for AIDS is taking place throughout the state and nation, at present, there is no solution to the AIDS problem. To date, the only way to stop the spread of AIDS is prevention. — *Susan Porter*

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OBITUARIES

JOSEPH AVELLONE, MD, Cleveland; Case Western Reserve University School of Medicine, 1947; age 61; died January 22, 1987; member OSMA and AMA.

ALBERT L. BERSHON, MD, Sarasota, Florida; Ohio State University College of Medicine, 1927; age 85; died January 13, 1987; member OSMA and AMA.

MILTON E. BOBEY, MD, Rocky River, Ohio; Case Western Reserve University School of Medicine, 1939; age 73; died January 19, 1987; member OSMA and AMA.

LEWIS W. CHALFIN, MD, Cleveland; Case Western Reserve University School of Medicine, 1927; age 82; died January 28, 1987; member OSMA and AMA.

WILLIAM C. COMPTON, MD, Wooster; University of Cincinnati College of Medicine, 1927; age 92; died December 28, 1986; member OSMA and AMA.

JOHN W. ERKERT, MD, Toledo; Northwestern University Medical School, Chicago, Illinois, 1939; age 73; died January 26, 1987; member OSMA and AMA.

HERBERT K. ERVIN, MD, Reynoldsburg; Ohio State University College of Medicine, 1946; age 64; died December 30, 1986; member OSMA and AMA.

LOUIS W. GAKER, MD, Hamilton; University of Cincinnati College of Medicine, 1922; age 88; died January 9, 1987; member OSMA and AMA.

W. JAMES GARDNER, MD, Shaker Heights; University of Pennsylvania School of Medicine, Philadelphia, PA, 1924; age 86; died January 29, 1987; member OSMA and AMA.

FRANK G. GUARNIERI, MD, Warren; Loyola University Stritch School of Medicine, Maywood, Illinois, 1933; age 80; died January 17, 1987; member OSMA and AMA.

MOSES HARTMAN, MD, Cleveland; Rush Medical School, Chicago, Illinois, 1933; age 81; died February 1, 1987; member OSMA and AMA.

STANISLAUS JAUDZENS, MD, Vermilion; Latvijas University Medicinas Fakultate Riga, Latvia, 1938; age 80; died December 26, 1986; member OSMA and AMA.

DICK LYLE, MD, Dayton; University of Iowa College of Medicine, Iowa City, Iowa, 1956; age 65; died February 3, 1987; member OSMA and AMA.

HARRY D. McAVOY, MD, Toledo; Hahnemann Medical College of Philadelphia, Philadelphia, Pennsylvania, 1943; age 72; died January 18, 1987; member OSMA and AMA.

JAMES R. MONROE, MD, Columbus; Ohio State University College of Medicine, 1949; age 62; died February 3, 1987; member OSMA and AMA.

PUNNAMMA R. RANGA, MD, Wapakoneta; Andhra Medical College, Andhra University, Visakhapatnam Andhra Pradesh, India, 1973; age 38; died January 28, 1987; member OSMA.

GABRIEL A. SABGA, MD, Lorain; Medical School of the American University of Beirut, Beirut, Lebanon, 1953; age 57; died January 11, 1987; member OSMA and AMA.

CLARENCE F. SCHMITT, MD, Canton; Case Western Reserve University School of Medicine, 1938; age 75; died February 3, 1987; member OSMA and AMA.

CHARLES B. TRAMONT, MD, Pompano Beach, Florida; New York Medical College, New York, 1937; age 82; died January 18, 1987; member OSMA and AMA.

DAVID VOLK, MD, Cleveland; Ohio State University College of Medicine, 1946; age 69; died January 10, 1987; member OSMA.

DANIEL WESTERBECK, MD, Cincinnati; University of Cincinnati College of Medicine, 1943; age 69; died December 21, 1986; member OSMA and AMA.

WILLIAM R. YOUNG, MD, Cleveland; Case Western Reserve University School of Medicine, 1954; age 58, died January 22, 1987; member OSMA and AMA.

Resident's Section

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—Warren Ljungren, MD
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Intern Programs

continued

Medical Society, 4150 Belden Village St., NW, Canton, Ohio 44718 (216) 492-3333. — *Karen S. Edwards*

Oscar Wilde in Ohio

By James G. Ravin, MD

The Anglo-Irish wit and author Oscar Wilde came to Ohio in 1882, during a yearlong tour of America. He was 31 years old and already a well known figure on both sides of the Atlantic for his witticisms and his flamboyance. He was the major spokesman of the Aesthetes, a group that advocated "art for art's sake," while *Punch* magazine continually satirized him for what it considered an unmanly concern with art. Gilbert and Sullivan's comic opera *Patience* was playing in London at the time, and its main character was based on Wilde.

As Wilde actively sought publicity, he was pleased to lecture in America. There had been a long history of English authors making speaking tours in this country. Charles Dickens came to Ohio during his lecture tour 40 years earlier, in 1842, when much of the state was wilderness.[1] Sir Arthur Conan Doyle spoke in several Ohio cities in 1922, 40 years after Oscar Wilde's visit.[2]

Product of a Medical Family

Oscar Fingal O'Flahertie Wills Wilde was born in Dublin, Ireland, in 1856, into a family that included two generations of physicians. His paternal grandfather, Dr. Thomas Wilde, had a large general practice and made rounds on horseback. Oscar's father, Sir William Wilde, was a famous eye, ear, nose and throat surgeon and antiquarian. Three years before Oscar was born, a special post was created for his father, surgeon-oculist-in-ordinary to the queen in Ireland. He was knighted in 1864. Oscar was named for his godfather, the reigning King of Sweden.[3] Sir William had performed a successful cataract operation on the Swedish king.

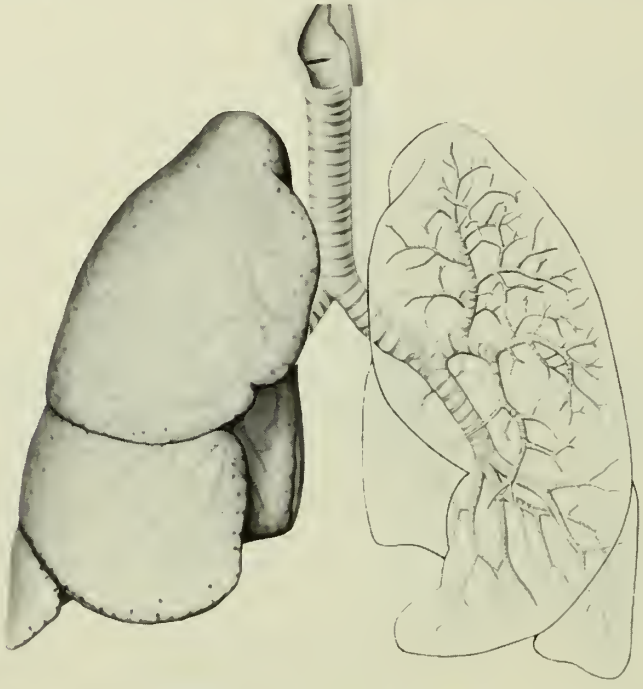
Sir William Wilde was charitable, and used the first thousand pounds he earned from practicing medicine to found St. Mark's Ophthalmic Hospital in Dublin. The poor from all over Ireland flocked to him throughout his career. He founded and edited the *Dublin Quarterly Journal of Medical Science* and wrote several books, including *Aural Surgery, Epidemic Ophthalmia,* and *The Epidemics of Ireland.* But his most important writings were not medical at all. His three volume *Catalogue of the Contents of the Museum of the Royal Irish Academy* has been considered "a monumental work of archaeological erudition and insight."[4]

Oscar's mother was an exceptional woman, and exerted far more influence on him than did his father. She was a glib conversationalist and noted writer. Under the pseudonym "Speranza" she wrote jingoistic prose and poetry, urging young Irishmen to take up arms against England. The newspaper for which she wrote was suppressed for sedition and its editor was prosecuted.

Oxford and Beyond

As an Oxford University student, Wilde charmed many with his wit while achieving first class

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awards in the classics and in literature and winning a coveted prize for poetry. He was exceptionally precocious, both mentally and physically. He was quite large, and was able to defend himself in fist fights and drinking bouts. Many tales have been told of his victories in each type of contest. But Oscar preferred "not to kick or be kicked." He became the "apostle of the aesthetic" and made the famous remark, "Oh, would that I could live up to my blue china."

By the time of graduation from Oxford in 1878, Wilde was well known. His maxims and aphorisms had already earned him the reputation of being one of the wittiest men of his time. He lived in London where he associated with James Whistler, the American painter, and greatly admired the stage beauty Lily Langtry.

On to America

Wilde seized the opportunity to come to the New World in 1882. This offered him a chance to perfect his speaking before audiences who he hoped would not be too critical, an opportunity to earn some income, and he hoped to have one of his plays produced on the stage in the United States.[5]

On his arrival in New York, he created an immediate sensation by stating he had nothing to declare but his genius and that he was disappointed with the Atlantic, since it was too tame. Statements of this sort were just what the press wanted, and earned him more publicity than did his lectures on aestheticism. American audiences considered him an extravagant "poseur," and could not take him seriously. They came to see him out of curiosity.

Some of his words about America are worth mention:

We have really everything in common with America nowadays, except, of course, language.
The discovery of America was the beginning of the death of art.
The America life is one long expectoration.
The Americans are certainly great hero-worshippers, and always take heroes from the criminal classes.
The crude commercialism of America, its materialist spirit, its indifference to the poetical side of things, and its lack of imagination and of high unattainable ideas, are entirely due to that country having adopted for its national hero a man who, according to his own confession, was incapable of telling a lie, and it is not too much to say that the story of George Washington and the cherry-tree has done more harm, and in a shorter space of time than any other moral tale in the whole of literature — and the amusing part of the whole thing is that the story of the cherry-tree is an absolute myth.
I believe a most serious problem for the American people to consider is the cultivation of better manners.
I would rather have discovered Mrs. Langtry than to have discovered America.
Niagara Falls — Simply a vast unnecessary amount of water going the wrong way and then falling over unnecessary rocks.†

Cleveland

The first lecture given by Wilde in Ohio was in Cleveland on February 18, 1882, and was reviewed at length in the *Cleveland Plain Dealer.* The newspaper said the audience came to see him rather than to hear him: "He is one of the awkwardest men who ever stood upon a lecture platform. His monotonous delivery chanted some of his hearers to sleep and made most of the others drowsy. Many were discourteous enough to leave the hall during the progress of the lecture. Mr. Wilde was arrayed in knee breeches, ribboned pumps and black silk stockings . . . Persons of pronounced individualities always have peculiarities. Wilde's costume and manner constitute his trademark."[7]

Cincinnati

Wilde travelled to Cincinnati, where he spoke on February 23, 1882. The lecture was well covered by the Cincinnati press with articles appearing in at least seven different newspapers. The *Cincinnati Daily Gazette* gave coverage beginning three days before the event and ending two days afterward. Wilde was described as having a "large long face, framed in thick locks of brown hair, parted in the center and falling on either side of the cheeks almost to the shoulders," giving him a "womanly air." He had "a bright smile and a perpetually changing expression, clear gray eyes, a tall and manly figure, a carriage the perfection of good form, and a bearing that bespeaks him a thorough man of the world." Wilde cordially answered the reporters questions, saying that he was pleased with America and felt that it had great possibilities. He felt that Ohioans and other Americans away from the eastern seaboard were delightful, and he appreciated the new and fresh spirit of our part of the country, where people were "generous and free from prejudice." Mr. Wilde said Easterners "are enveloped in imperfect mist of prejudice, quite unlimited; they have imported so many old world ideas, absurdities, and affectations that they have lost all sincerity and naturalness."[8]

The *Cincinnati Enquirer* gave Wilde an extensive report, finding

him to be pleasant and cordial. He was described in the following terms:

In person he is very tall, with broad shoulders and a plethora of arms and legs — that is, he has the usual complement of limbs, but they appear longer and more loosely jointed than perfect accord with manly beauty requires. His face is long and narrow, and appears narrower than it really is on account of the length of his hair, which is light brown in color, is parted in the middle, and touches the shoulders like a dark flaxen mane . . . In the left lapel of his coat was a beautiful rosebud, and he held another in his left hand, whose delicate exhalations he ever and anon enhaled with evident rapture. Oscar was not a beautiful object for the eye to rest on. His clothes, especially his trousers, were horribly ill made, and if he were to bring an action for damages against his tailor, he could get a verdict in his favor in any city in the country where the work of a decent slopshop could be offered in evidence as an approach to what should be the proper habiliments of a gentleman.

One woman was quoted as saying, "What an ugly, ungainly looking man he is." Even his manner of speech was reported negatively. "He is a very poor speaker, his voice being nasally and far from mellifluous. He drawls his words in an unpleasant monotone, and his pronunciation is 'awfully English,' and abounds in 'shawants,' 'cowants,' etc." In his lecture, Wilde said, "We are now trying to bring together the handicrafts, man and the artist, as they were back in the days of Grecian art."[9]

Dayton

After an extended visit to the far West, Wilde returned to Ohio and spoke in Dayton. The *Dayton Daily Journal* of Wednesday, May 3, 1882 noted that Wilde was large and athletic but not handsome. His eyes were small but gave "a frank hearty expression, twinkling with amusement and brightening with enthusiasm" when he dwelt on subjects that pleased him. He was found to be an expert conversationalist with an easy manner. When told that the Miami River flowed through the area, he said, "Ah, how lovely are those Indian names." As he rode over the river in a carriage, he said, "You should never let your manufacturers pollute the air with smoke," and recalled seeing a cloud of smoke over Cincinnati. He remarked, "I was astounded — how long can beauty exist among so much that is vile?"[10]

Columbus

From Dayton Wilde travelled to Columbus and spoke there on Wednesday, May 3, 1882. This was reported in the *Ohio State Journal* the following day. The newspaper stated "the aesthete has not absorbed much of the beautiful in his person." His long hair gave him a "striking resemblance to Buffalo Bill . . . It is when he speaks that he is admired." In marked difference from his own background, Wilde said that children should not "pour over musty books when they should be out in the field and forest, where they would learn truths in the natural way." The newspaper report continued, "It is utterly impossible to do the lecture justice by any sort of an abstract. The speaker, with a brilliancy of thought, peculiar grace of delivery and thorough knowledge of his subject, is eminently at home with the subject of art. Whatever peculiarities he has as a man, he is a great exponent of the beautiful. His lecture was a rare treat to all lovers of art."[11]

Cincinnati Revisited

Wilde returned to Cincinnati for a lecture on June 11, 1882. The *Cincinnati Daily Gazette* was not greatly impressed, entitling his review "Sunday Aestheticism," and subtitling it "An Old Discourse Under a New Name — The Old Platitudes Revamped." The reviewer noted that the bulk of people attending the lecture went to hear him talk about art, while "the rest went out of sheer curiosity to see the great apostle of the new English art revival. Mr. Wilde should never lecture twice in the same field."[12]

Nor was the *Cincinnati Enquirer* any more favorable in an article entitled "Hosscar Wilde" and subtitled "The Asthetic Sham's Idle Transcendental Chatter."[13]

The *Cincinnati Commercial* was no less disparaging. In a review entitled "The Droning Aesthete," the *Commercial* said:

As the lecturer belongs to the clique in London which has paid particular attention to household decorative art, it was thought by some that his lecture would contain some definite directions, some clear, concise rules for a basis of forming a household art in America. Such persons were disappointed, because the most startling portions of his lecture were his asthetic costume of black velvet and his efforts to make a graceful curve out of the angle of his left elbow.– ×

Back in Britain

After recrossing the Atlantic, Wilde toured England, giving a series of lectures entitled *Impressions of America.* The size of our country impressed him, as if it were trying to "bully one into a belief in its power." He found America cities lacked the beauty of



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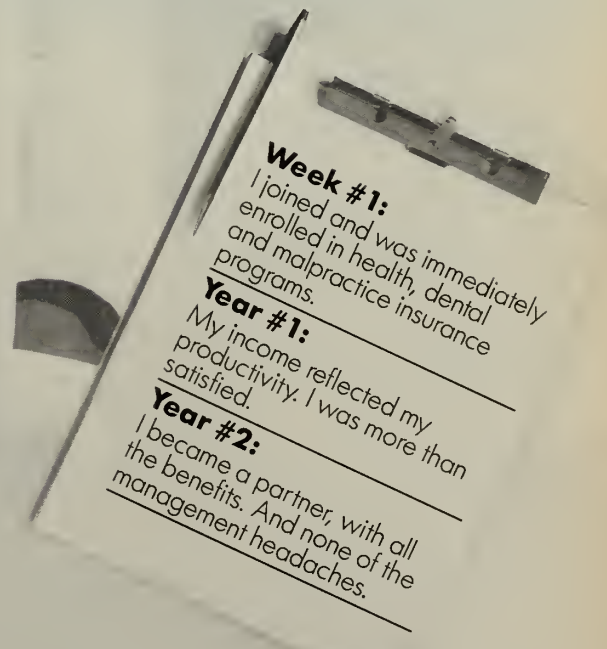
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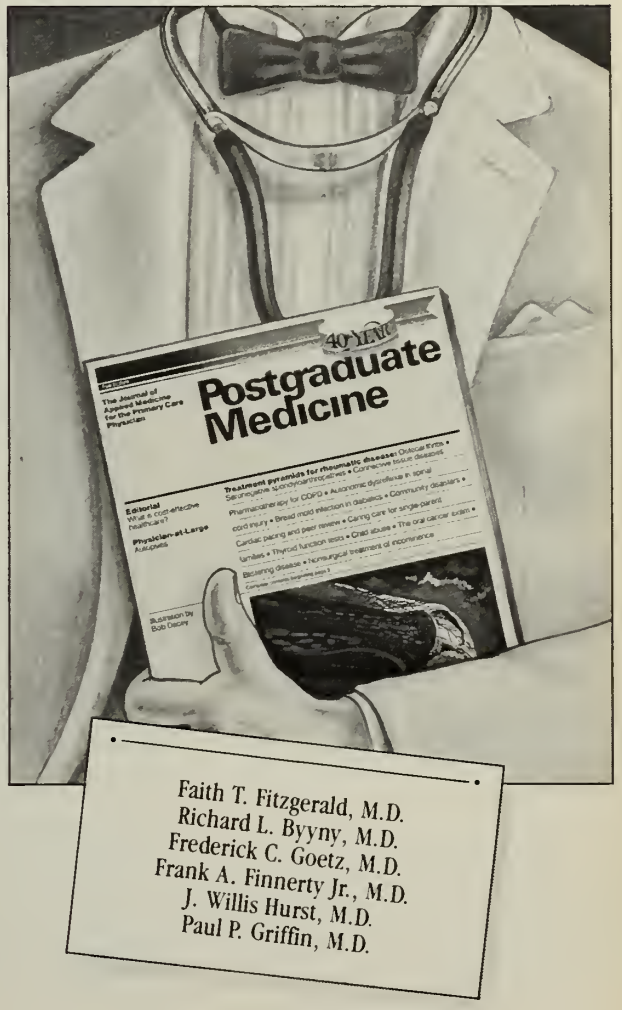
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many British cities, and said that when Americans tried to create beauty they failed. A notable American success, he continued, was the ability to apply scientific advances to modern life. American inventors were honored and often became wealthy, while English inventors were considered nearly crazy and often stayed poor. American men were practical, energetic, and shrewd in business. He found the American emphasis on acquiring a business sense early in life useful, something that Englishmen missed when away at school. Americans understood people better than books, and life interested them more than literature. American men studied stock market quotations and newspaper editorials, but lacked culture, and had no interest in history or in beauty. To the American man civilization began with the introduction of steam power, and everything before that time merited his contempt. American men were charming at home, but bewildered and out of place when abroad. The American traveler would want the Colosseum in Rome covered with a glass roof and converted into a warehouse, he joked. "Bulk is his canon of beauty and size his standard of excellence."[15] With naivete and nonchalance the American, said Wilde, would compare European palaces and cathedrals to American train stations and Niagara Falls. To the American the greatness of a country depended on the number of square miles it contains, he said.

Wilde found American women charming, and they were very curious about him. When back in England he liked to say that he had employed two secretaries in America, one responsible for autographs and the other for locks

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of hair. In six months the first had died of writer's cramp, and the other was completely bald.

Downfall

"Life imitates art," Wilde wrote in *The Decay of Lying,* and his own pleasures exceeded the boundaries of his era. He had maintained a long relationship with a son of the Marquess of Queensbery. When Queensbery accused him of being a sodomite, Wilde sued for libel. The evidence went against Wilde. He was arrested, tried, found guilty, and sentenced to two years at hard labor in 1895. On release from prison in 1897, he was bankrupt. He moved to France where he died in 1900 of meningitis following an ear infection.[16]

His Contributions

While at Oxford Wilde said, "I'll be a poet, a writer, a dramatist. Somehow or other I'll be famous, and if not famous, I'll be notorious." He lived up to his aspirations.

His writings are clever, and some are masterpieces, but they leave us feeling that he has just scratched the surface of his ability. This was the essence of Oscar Wilde, for, as he said, "I put all my genius into my life; I put only my talent into my works." In a similar vein he wrote, "Life is too much too important a thing ever to talk seriously about it."

Wilde was better at conversation than at lecturing or writing. George Bernard Shaw, a fellow Irishman, paid him a compliment by saying, "He was incomparably the greatest talker of his time, perhaps of all time." Ohioans a century ago were privileged to be able to hear this unique individual dramatist. **OSMA**

James G. Ravin, MD, a Toledo ophthalmologist, writes frequently for **Ohio Medicine** *on the subject of authors and artists. A past chairman of the OSMA's Art and Culture Committee, he continues to serve as a member of that committee.*



Oscar Wilde. Photograph taken in 1882 by N. Sarony of New York. Library of Congress, Washington, D.C.

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In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.
The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone
The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

HOW SUPPLIED

Transderm-Nitro System Rated Release *in vivo*	Total Nitroglycerin in System	System Size	Carton Size
2.5 mg/24 hr	12.5 mg	5 cm^2	30 Systems (NDC 0083-2025-26) *100 Systems (NDC 0083-2025-30)
5 mg/24 hr	25 mg	10 cm^2	30 Systems (NDC 0083-2105-26) *100 Systems (NDC 0083-2105-30)
10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26) *100 Systems (NDC 0083-2110-30)
15 mg/24 hr	75 mg	30 cm^2	30 Systems (NDC 0083-2115-26) *100 Systems (NDC 0083-2115-30)

*Hospital Pack 100's

C85-35 (Rev 11/85)

Dist. by:
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA.

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C I B A

CLASSIFIED ADVERTISING

OSMA Classified Advertising

The OSMA offers classified advertising under headings designed to serve OSMA members and the medical community. Categories generally available are: employment opportunities, equipment for sale, medical office space for sale or lease, medical practices for sale, positions wanted, services and CME seminars.

Classified Advertising Rates

$1.50 per word for regular ads with bold title, $1.75 per word for ads appearing in a box. Payment for the ad must accompany advertising request. Ads must be typed. Closing date for classified ads is first day of month preceding publication.

The OSMA Journal reserves the right to refuse or delete classified ads without explanation and to refer advertisements of a commercial nature to the display advertising department, at the publisher's discretion.

Send classified ads to:
Ohio Medicine
600 South High Street
Columbus, Ohio 43215
Attention: Classified Ad Manager

Telephone orders for classified ads are not accepted.

Employment Opportunities

ARNELL ENGSTROM CHILDREN'S CENTER ADVERTISEMENT FOR CHILD/ADOLESCENT PSYCHIATRIST
Needed: March, 1987

Child/adolescent psychiatrist, Board eligible, preferred certified, to work closely with a multidisciplinary team in an accredited 40-bed child and adolescent psychiatric hospital, an agency of the Michigan Department of Mental Health. We are located in beautiful Traverse City, Michigan. A water and winter wonderland. Traverse City is the cultural and medical center for Northern Michigan. Skiing, fishing, hunting and sailing are at your doorstep. We have an excellent school system and a pollution free, low crime environment. Salary depending upon qualifications to $86,000 with remarkable fringe benefits. Send curriculum vitae and three letters of reference to Arnell Engstrom Children's Center, Box C, Traverse City, Michigan 49684, or call Robert E. Davidson, MD, or Paul Surratt, PhD, at Area Code 616/922-5400.
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EXCELLENT OPPORTUNITIES FOR — Otorhinolaryngologist, Psychiatrist, Endocrinologist, Radiologist, Orthopedist, and General/Family Practitioner. Excellent opportunity for physicians in Los Angeles suburb to join 80 member prepaid practice, no Medi-Cal. Excellent compensation program based on guarantee plus incentive, profit sharing and pension plan. Group provides health, dental, life and malpractice. Partnership in real estate and medical corporation available. See our Ad in this publication. Send CV to Wm. Shaw, Associate Administrator, Mullikin Medical Center, 17821 S. Pioneer Blvd., Artesia, CA 90701.

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FAMILY PRACTICE
Boarded or Board Eligible family practitioners are needed to meet our patient population growth in 1987. Our multi-specialty group practice offers an excellent salary and fringe package and a good group of residency trained, boarded Family Practitioners with whom to work. C.V.s to Search Committee, Group Health Associates, 2915 Clifton Avenue, Cincinnati, Ohio 45220.

FAMILY PRACTICE OPPORTUNITY. Thriving Family Practice in Ravenna, Ohio is available immediately. Ravenna is in northeast Ohio, Portage County seat, population 12,000; however, the practice draws from the entire county of 130,000. Superb community hospital of 286 beds with almost all specialties available. Present practitioner leaving to assume medical directorship of the hospital and will be available to introduce. Desire FP with Boards or soon to take them. Terms negotiable. Write to: David S. Palmstrom, MD, 250 South Chestnut Street, Ravenna, Ohio 44266, or phone 216-296-9606.

GENERAL PHYSICIANS AND PSYCHIATRISTS NEEDED. Contact: Annashae Corporation, 6593 Wilson Mills Road, Mayfield Village, Ohio 44143-3404. (216) 449-2662.

HOUSE PHYSICIANS: Full-time and part-time Medical/Surgical and OB/GYN House Physician positions available in July, Ohio license required. Prefer board eligible/board certified physician. Hospital is a community teaching hospital. Attractive salary and benefits. Contact Barberton Citizens Hospital, c/o House Physician Recruitment, Tuscora Park, Barberton, Ohio 44203. EQUAL OPPORTUNITY EMPLOYER. m/f/h.

HUSBAND-WIFE FPs
Residency trained husband-wife FPs seeking same. Guarantee 180 K/Yr. Excellent community hospitals. Thriving Lake Erie coastal town. Begin July 1988. Interviewing now. Send or call for particulars. Contact Jay and Jerri Nielsen, M.D.s' Paradocs, Inc., 1015 W. Washington Street, Sandusky, OH 44870 (419) 626-5612.

INTERNAL MEDICINE
Our multi-specialty group practice continues to grow. We need Board Certified/Board Eligible internists to meet the needs of our increasing patient population. Both our compensation package and practice environment are attractive. Positions are available in January and July of 1987. Send your C.V. to Search Committee, Group Health Associates, 2915 Clifton Avenue, Cincinnati, OH 45220.

MEDICAL ASSOCIATE to join older internist-established practice — good clientele. City NW Ohio — 40,000. Modern office, X-ray, M.T. (ASCP) laboratory. Attractive offer. Family Practice or internist, BE/BC. Call 419-422-7623.

OB/GYN, ORTHOPEDIC SURGEON: Board certified or eligible to join 15 member group in progressive northwestern Wisconsin community. Modern, well-equipped hospital located adjacent to our facility. Close to Minneapolis, Eau Claire and Duluth, the Rice Lake area offers excellent educational, religious and community activities in addition to exceptional sports, hunting, fishing, and recreational opportunities. For more detailed information regarding our group, please contact Mark T. Nymo, MD, Indianhead Medical Group, 1020 Lakeshore Drive, Rice Lake, WI 54868 (715) 234-9031.

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Mercy Health Care System consists of 49 health-related corporations in Ohio, Kentucky and Tennessee, including 15 hospitals. Currently we have several opportunities, most offer first year income guarantees and generous benefits.

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- **HOSPITAL-BASED EMERGENCY MEDICINE** physician wanted for 100 bed hospital.
- **FAMILY PRACTICE** physician needed for suburb located on Lake Erie.
- Established **OB/GYN** practice for sale in Central, Ohio city.
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- **NON-INVASIVE CARDIOLOGIST** wanted for Central, Ohio town. Experience required in interpretation of EKGs, Holter monitors, Echo dopler and Carotid duplex.
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- **FAMILY PRACTICE** physician wanted for rural Indiana town.

Contact: Dr. Charlotte Mackenson-Dean
Director, Physician Recruitment
Mercy Health Care System
2303 Grandview Avenue, Cincinnati, Ohio 45206-2278
513-221-2736 — In Ohio, 1-800-582-7068

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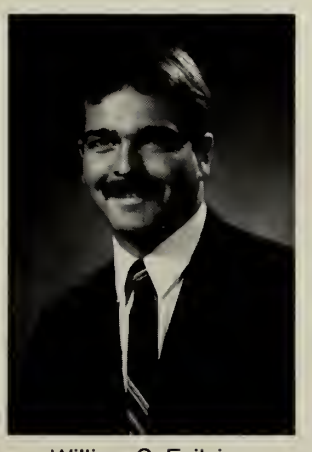
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PIE MUTUAL INSURANCE COMPANY 100 Erieview Plaza Cleveland, OH 44114

OBERLIN, OHIO 21 person multispecialty group seeks additional BC/BE family physicians, internist, cardiologist, and otolaryngologist. North central Ohio college town serving drawing area of 290,000. Salaried position first year; full shareholder status available in second year. Send CV to Dr. VanDyke, 224 W. Lorain, Oberlin, OH 44074.

OBSTETRICIAN/GYNECOLOGIST (BC/BE). Immediate opening to join an established and growing two-man practice in South Central Ohio. Experience in Ultrasound, Infertility, and Microsurgery desired. Excellent professional and recreational opportunity. Modern 225-bed hospital serving pop. of 60,000+. Send CV to: Center OB-GYN Associates, Inc., PO Box 969, Station A, Chillicothe, OH 45601, 614/773-1133.

OHIO: Emergency Medicine positions ranging from part-time placements to full-time Directorships. Low to high volume hospitals throughout the state. Guaranteed hourly rate plus malpractice insurance. Contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 26, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

OHIO, NORTHEAST/CLEVELAND: Staff position for Board Certified/prepared in emergency medicine or other primary care specialties for ED, 8000-32000 patient visits per year. Exc. compensation & benefit pkg: pd. health, life, disability, and dental ins; pension and PS plan; educ. stipend; and vac. Professional liability coverage paid by corp. Advancement to shareholder level for well-qualified individual. Please send CV to PO Box 2600, Lakewood, Ohio 44107.

OHIO PHYSICIAN OPPORTUNITIES — Board certified/eligible family practice, general surgeon and orthopedic surgeon needed in south-central Ohio. Easy access to Columbus, Dayton and Cincinnati. 50,000 population trade area with 70-bed hospital. Some opportunities to join existing practice. Excellent schools/family community/many recreational opportunities. Competitive compensation package. Contact: H. James Graham, Fayette County Memorial Hospital, 1430 Columbus Ave., Washington Court House, OH 43160 — (614) 335-1210.

THE OHIO STATE UNIVERSITY Department of Internal Medicine has two openings in its new Division of Community Internal Medicine. This South Central Ohio primary care general medicine group will consist of six general internists in a key referral area of the University. Full-time faculty appointments will be offered, with the full range of fringe benefits. Salary negotiable. Positions available January 1987. Please send resume to Ernest L. Mazzaferri, MD, Chairman, Department of Internal Medicine, 215 Means Hall, 1654 Upham Drive, Columbus, OH 43210-1228. The Ohio State University is an Affirmative Action/Equal Opportunity Employer.

PEDIATRICIAN. Solo practice available immediately. SE Ohio, City 35000. Accredited hospital, 1 hour from any place in Columbus. Gross $225,000+. Practice free to pediatrician who will rent fully equipped office. Will introduce. Respond to Box 126, c/o Ohio Medicine, 600 S. High Street, Columbus, Ohio 43215 with curriculum vitae.

PHYSICIAN

Group Health Associates is searching for that particular physician interested in working full-time (40 hours per week) in our Clifton Urgent Care Department. We have an excellent compensation package and good support services. This position requires no hospital responsibilities or continuing patient care. Please send your C.V. to Search Committee, Group Health Associates, 2915 Clifton Avenue, Cincinnati, OH 45220.

PHYSICIAN WANTED to join busy, established family practitioner in a lovely college town in Central Ohio. Obstetrics optional. This is a satellite operation of a well-established multispecialty group practice just 18 miles distant. Shareholder status in the parent group available after the first year. Very competitive starting salary with superb fringe benefits. Please reply to PO Box 95, c/o Ohio Medicine, 600 S. High Street, Columbus, OH 43215.

PRIMARY CARE PHYSICIANS. Multistate practice association seeks BE/BC primary care physicians for unique opportunities in PA, NJ, New England, MD, FL, and other areas of the US. Most positions offer Monday-Friday 8 am to 5 pm schedules with up to five weeks paid time off. Paid malpractice. Contact or send CV to Pennhurst Medical Group, PC, Scott Plaza Two, Suite 114, Philadelphia, PA 19113, 215/521-5100 or outside PA, 800/872-8626.

PSYCHIATRIST

Due to expansion and growth, 45 member multispecialty group practice has an opening for a Board Eligible/Board Certified psychiatrist. Our group provides all the medical services for a 40,000+ member HMO and our own private pay patients. We offer a competitive salary structure and fringe benefit package to include participation owner of the medical group and coverage of virtually all practice expenses. We welcome inquiries for psychiatrists interested in merging their existing practices with ours. Our practice environment is challenging and professionally stimulating. Forward inquiries and C.V.s to: Search Committee, Group Health Associates, Inc., 2915 Clifton Avenue, Cincinnati, OH 45220.

PSYCHIATRISTS. Immediate openings for Staff Psychiatrists, full time and part time, board eligible/board certified, in a state-operated, JCAH accredited, 380-bed inpatient psychiatric hospital. Multidiscipline approach with psychiatrist as a treatment team leader, expected to exercise strong leadership in quality care of patients. Programs for acute admissions, extended care, geriatrics and psychiatric rehabilitation. License to practice in the state of Ohio is required. We are located about 20 miles from Akron, population: 300,000; excellent school system and outdoor activities. Massillon and adjacent Canton has a combined population of 110,000. Salary starts at $54,308 annually, with expected increase to $57,034 on 1/1/87. Excellent fringe benefits including paid vacation and personal leave, sick and educational leave, health, vision, dental and life insurance, etc.

Travel costs may be negotiated. Faculty appointment to the Northeastern Ohio University College of Medicine possible for qualified applicants. EEO Employer, M/F/H.

Send resume to W.J. Roberts, Director of Personnel, Massillon State Hospital, Box 540, Massillon, OH 44648, or call (216) 833-3135, ext. 223.

RADIOLOGIST for a busy diagnostic center. General radiology and ultrasound experience in northeast Ohio. Salary negotiable. Reply 361 East Waterloo Road, Akron, Ohio 44319.

WESTERN PENNSYLVANIA. BC/BE primary care physicians to join group of four doctors who enjoy working Monday-Friday 8:30-5:00. Optional on-call coverage if desired. Benefits include four weeks vacation, one week CME, 10 holidays, plus malpractice coverage. Facility located one hour east of Pittsburgh suburbs. Must be PA licensed. Call (215) 592-7400 or (1-800) 331-7122 outside PA, or send CV to Liberty Healthcare Corporation, 399 Market Street, Suite 400, Philadelphia, PA 19106.

Equipment

WANTED TO PURCHASE: Used teaching scope attachment for the Olympus OSF 60 cm. Flexible Sigmoidoscope. Also would consider purchase of a used OSF 60 cm. Olympus Sigmoidoscope if in good working condition. Phone 513-522-5180.

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OFFICE FOR RENT in established medical building in Wooster. Good location. Call Dr. Brant 216-262-4901 days.

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Position Wanted

POSITION DESIRED. 58 years of B.E. OB-Gyn, Licensed in Ohio. Looking for a position in any institution. Phone area code 614-353-1553 or 614-858-6213.

Practice for sale

MEDICAL PRACTICE FOR SALE — Active ENT & allergy practice for sale. Solo physician retiring NE Ohio. Excellent hospital facilities. Reply to: Attorney Ralph Higgins, Westview Towers, 21010 Center Ridge Road, Rocky River, OH 44116.

SINGULAR OFFER — FOR SALE OR GUARANTEED LEASE ARRANGEMENT: Well established orthopedic solo practice. Coverage available. Lake Erie — Port Clinton — Catawba: growing resort and industrial area. Office building with physio-therapy and x-ray. Micro-filmed records 20+ years. Will introduce. D.W. Felber, MD, 730 Jefferson Street, Port Clinton, OH 43452 — Telephone: 419-734-2109.

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Poor risk

Chances of getting cancer and dying from it are disproportionately higher among poor Americans, according to a special report from the American Cancer Society (ACS).

The report, "Cancer in the Economically Disadvantaged," pointed out that low income individuals tend to enter the health care system later, with diseases well beyond treatment stage.

CORRECTION —
Diagnosing and Treating Memory Loss

Ohio Medicine received numerous letters regarding inaccuracies which occurred in the article "Yesterday Never Happened — Diagnosing and Treating Memory Loss" (January, 1987). We wish to apologize for the errors made and to correct them at this time:

*A. Dale Gulledge, MD, is the Head of the Section of Liaison Psychiatry, not the Department of Psychiatry.

*Maurice R. Hanson, MD, is the Acting Medical Director of the Center of Aging.

*Digitalis preparolis should have read digitalis preparation.

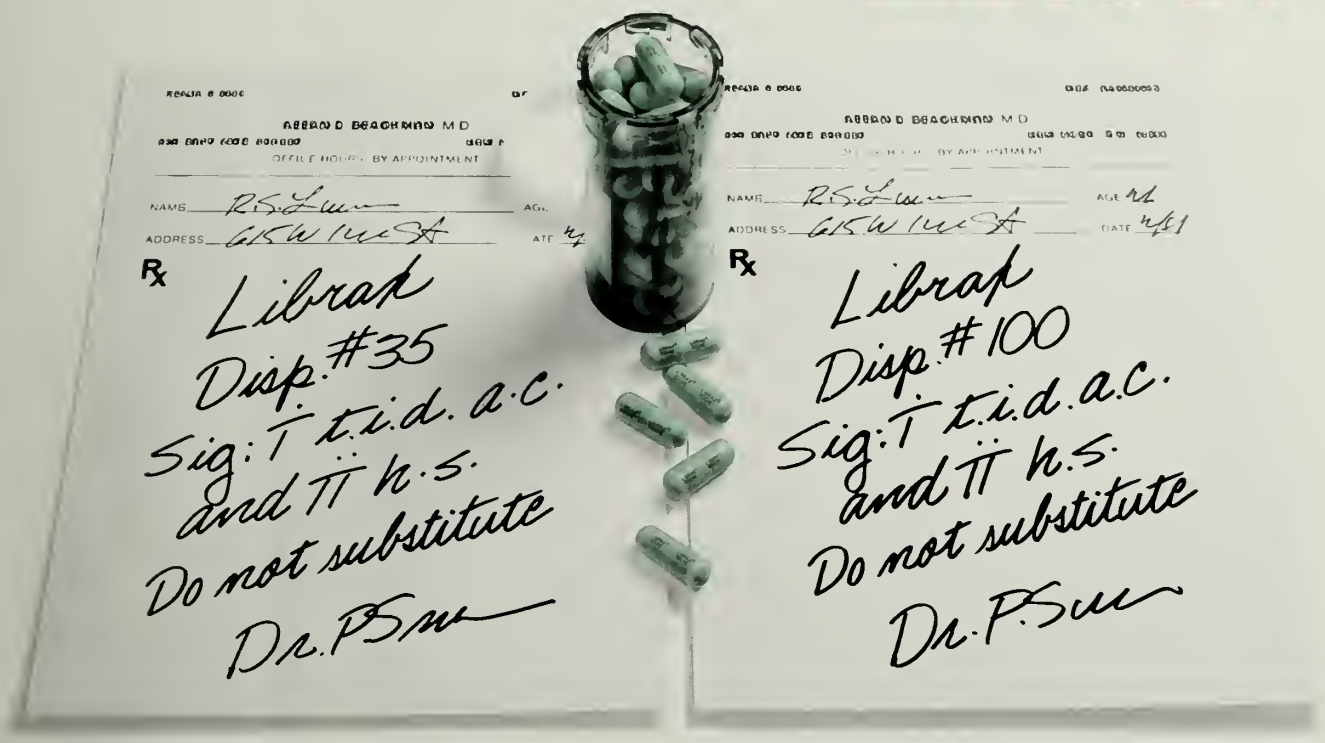
*Huntington's disease was incorrectly identified as a slow viral infection; and according to Dr. Gulledge, dementia cannot be determined by demonstrating atrophy on a CT scan.

*Benzodiazepine and Lorazepam were both misspelled and

*Hydrocephalus was incorrectly identified as hydrocephalitis.

(Editor's Note: *The information for this article was obtained from a videotape, and not from interviews with the participants themselves.)*

SPECIFY LIBRAX



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/ Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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FLARE-UP



SPASM AND PAIN CAN SIGNAL FUNCTIONAL GI DISORDERS*

Patients experiencing symptoms of irritable bowel syndrome* or duodenal ulcer* can often have emotional stress operating in the background. When you prescribe Librax for these patients, they receive treatment for both the emotional and the somatic elements to help relieve the anxiety/pain cycle.

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LIBRAX: FOR THE DUAL PROBLEMS OF FUNCTIONAL GI DISORDERS.

SPECIFY ADJUNCTIVE

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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

ANTIANXIETY
ANTISECRETORY
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*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of duodenal ulcer and the irritable bowel syndrome.

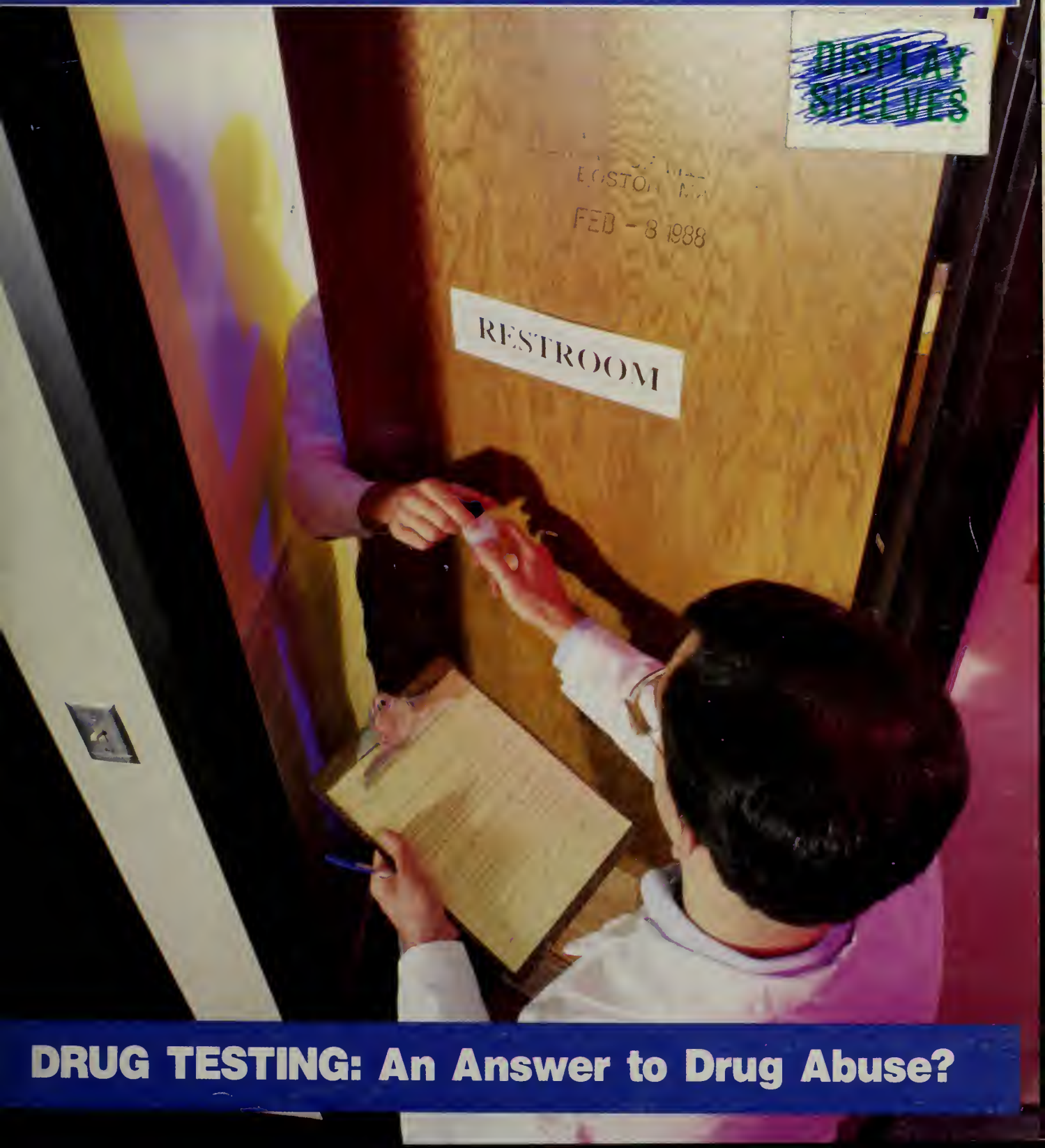
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OHIO Medicine

JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

VOL. 83, NO. 5 MAY, 1987



DRUG TESTING: An Answer to Drug Abuse?



A million and 1

Good mornings after a good night's sleep[1-3]...
that's what physicians have been providing for over 17 years with their prescriptions for Dalmane (flurazepam HCl/Roche).

A study of 2542 patients demonstrated that the great majority—97%—awake rested and refreshed.[3]

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flurazepam HCl/Roche
sleep that satisfies
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References: 1. Zimmermon AM. *Curr Ther Res 13*: 18-22, Jon 1971. 2. Amrein R, *et al. Drugs Exp Clin Res 9*(1):85-99, 1983. 3. Greenblott DJ, Allen MD, Shoder RI. *Clin Pharmacol Ther 21*: 355-361, Mor 1977.

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Indications: Effective in oll types of insomnio choroc-terized by difficulty in tolling osleep, frequent nocturnol owokenings ond/or eorly morning owokening, in patients with recurring insomnio or poor sleeping hobits; in ocute or chronic medicol situotions requiring restful sleep. Objective sleep loborotory doto hove shown effectiveness for ot leosf 28 consecutive nights of odministrotion. Since insomnio is otten tronsient ond intermittent, prolonged odministrotion is generolly not necessory or recommended. Repeoted theropy should only be undertoken with oppropriote potienf evoluotion

Contraindicotions: Known hypersensitivity to flurozepam HCl; pregnoncy. Benzodiozepines moy couse fetol domoge when odministered during pregnoncy. Severol studies suggest on increosed risk of congenitol molformations ossocioted with benzodiozepine use during the first trimester. Worn potients of the potentiol risks to the fetus should the possibility ot becoming pregnonf exist while receiving flurozepom. Instruct potients to discontinue drug prior to becoming pregnont. Consider the possibility ot pregnoncy prior to instituting theropy

Wornings: Coution potients obout possible combined effects with olcohol ond other CNS depressonts. An odditive effect moy occur if olcohol is consumed the doy following use for nighttime sedotion. This potentiol moy exist for severol doys following discontinuotion. Coution ogoinst hozordous occupotions requiring complete mentol olertness (*e.g.*, operoting mochinery, driving). Potentiol impoirment of performonce ot such octivities moy occur the doy following ingestion. Not recommended for use in persons under 15 yeors of oge. Withdrowol symptoms rorely reported, obrupt discontinuotion should be ovoided with groduol topering of dosoge for those potients on medicotion for o prolonged period ot time. Use coution in odministering to oddiction-prone individuols or those who might increose dosoge

Precoutions: In elderly ond debilitoted potients, it is recommended thot the dosoge be limited to 15 mg to reduce risk of oversedotion, dizziness, confusion ond/or otoxio. Consider potentiol odditive effects with other hypnotics or CNS depressonts. Employ usuol precoutions in severely depressed potients, or in those with lotent depression or suicidol tendencies, or in those with impoired renol or hepotic function.

Adverse Reactions: Dizziness, drowsiness, lightheodedness, stoggering, otoxio ond folling hove occurred, porticulorly in elderly or debilitoted potients. Severe sedotion, lethorgy, disorientotion ond como, probobly indicotive ot drug intoleronce or overdosoge, hove been reported. Also reported: heodoche, heortburn, upset stomoch, nouseo, vomiting, diorrheo, constipotion, GI poin, nervousness, tolkotiveness, opprehension, irritobility, weokness, polpitotions, chest poins, body ond joint poins ond GU complaints. There hove olso been rore occurrences ot leukopenio, gronulocytopenio, sweoting, tlushes, difficulty in focusing, blurred vision, burning eyes, tointness, hypotension, shortness ot breoth, pruritus, skin rosh, dry mouth, bitter toste, excessive solivotion, onorexio, euphorio, depression, slurred speech, confusion, restlessness, hollucinotions, ond elevoted SGOT, SGPT, totol ond direct bilirubins, ond olkoline phosphotose; ond porodoxicol reoctions, *e.g.*, excitement, stimulotion ond hyperoctivity

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FROM THE EDITOR

Drug Testing . . . and the spirit of caring in Ohio

This past March, the Ohio State Medical Association sponsored a public forum in Columbus on the subject of drug testing.

"The OSMA has no preconceived policies on this issue," said John E. Albers, MD, OSMA President, in an opening speech. As he pointed out, the forum, which was open to all segments of the community, was simply designed to explore the issue further . . . to determine whether or not policies regarding drug testing should be made. The discussions held at that forum are presented here in the form of two articles. The first deals with the legalities, the ethics and the costs of drug testing; the second, by Associate Editor Susan Porter, focuses on drug testing programs that have already been established, and how they are working out. Also included is the result of a survey on drug testing which the OSMA sent to its members. There were well over 1000 responses, so obviously the subject is one that you, the physician, must have strong feelings about. We hope this month's focus on drug testing and its use in the workplace (as well as the locker room) will answer some questions and offer new insights. And if you have a strong feeling, one way or another about the subject, send us a letter, or a "Second Opinion." We're happy to give both sides "equal time."

Also in this issue, you'll find we've tried something new. Rather than simply acknowledging the theme of this year's Annual Meeting, we decided to find out exactly what "the spirit of caring" means to the physician who must constantly balance empathy with scientific logic; compassion with cold, hard facts. So, we sat down with a list of OSMA delegates and asked 41 of them to respond to the question, "What does the spirit of caring mean to you?" The response was gratifying, and, we think, enlightening. At a time when the image of medicine is seemingly battered on all fronts, we have proof that the profession is still altruistic, still holds fast to the belief that harkens back to Hippocrates — that the medical profession *is* a caring profession. We hope you enjoy the responses that reaffirm this again and again. And look for us to try this kind of "question-answer" format again.

To carry the "spirit of caring" one step further, Assistant Editor Deborah Athy has profiled a very unique physician family for this month's "Out of Practice" column. We think you'll agree that the Janiaks — both Dr. and Mrs. — embody the spirit of caring in their personal as well as their professional lives.

Our departments carry a lot of interesting news this month — and "Your Financial Advisor" is back with James Budros discussing "Total Return Investing." Also, you'll want to make time to read this month's book review and essay. They're both well worth the short time you'll spend.

We know that as this Annual Meeting draws to a close that the spirit of caring will continue in Ohio, as delegates and alternates, councilors and officers return to their practices . . . and their patients. *Ohio Medicine* wants to thank everyone who responded to our query — and to salute, with pride, Ohio's caring physicians. We knew, all along, you were out there . . .

Karen S. Edwards

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JOURNAL COVER

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(b). A copy of the manuscript should be retained by the Author.

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(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

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"2. Doe J, Roe RX: How to go about it. Ohio State MJ 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: Modern Medicine, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

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A Legacy of Involvement



A year passes very quickly and my year as President of your Ohio State Medical Association is drawing to a close. As I prepare this last Presidential Page, I reflect on what an exciting and challenging year this has been for organized medicine, and I hope that I have represented you well as your President.

When finishing a position such as this, one always likes to consider what has happened, what progress has been made and where the future will be. Instead of looking back over the year and becoming self-praising as to our accomplishments, I believe that it is better to look toward the future, which will be in the capable hands of our new President, Ross Irons, MD, from Bellevue, Ohio. From my conversations with Ross, I know that he has great plans for the organization and will represent all of us very well. No matter how well Ross or any other individual who is the President or a leader of your association represents you, it makes very little difference in the total outcome if there is no grass roots physician support and involvement in what has to be done. I have heard many complaints time and time again — "We ought to do this, we ought to do that, why do you let them do that?" I know that I am not the first President to hear this and will not be the last. Why is this so? Is it a feeling of apathy or is it a feeling that one voice does not make any difference. Do individual physicians think that no one wants to hear what they have to say or is it really just a lack of involvement on the part of the one who is talking? There has hardly been a time when I have sat down at a lunch table at one of the hospitals and questions have not been asked by someone in reference to what the state is doing about this and that; particularly in reference to the recent Medicare changes. I sometimes answer with, "We are doing all we can," and occasionally I say, "What are you doing?" The state has sent reams of material to educate you on the new laws and the new changes. We have solicited advice from members. We have asked that members write to their congressman and state representatives, who are the ones who make these regulations and pass these laws. Often when I ask the question whether they have written or talked to their congressman, there is a deafening silence.

"My one legacy that I would like to leave Ross Irons for the future is that there will be more involvement by the membership."

Your organization, the Ohio State Medical Association, can do very little alone. It can do a tremendous amount with your support. Financial support, sure. No question that running the organization and providing all the services that the Ohio State Medical Association provides to its members requires a fairly substantial budget. Personal effort support from the members in doing something themselves — that does not cost any money but does cost some time — can be most effective. My one legacy that I would like to leave Ross Irons for the future is that there will be more involvement by the membership, and that he will see this and be able to testify before state committees and other committees that he does have the backing of his membership. The members of the House and Senate will know that he has that backing because they will have heard personally from the physicians on these issues.

Ross, as our new President, needs you. You also need Ross and the other leaders of the Ohio State Medical Association. Together we can be a vital force and make changes in the future.

I wish to thank all of those who have cooperated with me and worked with me during this past year, and especially thanks to the wonderful staff of the Ohio State Medical Association.

John E. Albers, MD
President

LETTERS TO THE EDITOR

BuSpar is clarified

To the Editor:

I would like to correct an error in the January, 1987 *Ohio Medicine* column entitled "OSMA News." BuSpar was reported as a "new antidepressant" in that column but it is, in fact, a new *anxiolytic*. It has not been FDA-approved for *or* marketed as an antidepressant as it does not appear to have significant primary antidepressant activity. BuSpar promises to be a breakthrough in the treatment of anxiety disorders and has a very favorable side effect profile, although one to two weeks of continuous, divided-dose therapy is usually required before therapeutic benefit is realized.

Thank you for clarifying this error.

Sincerely,
George R. Brown, MD
Dayton

To the Editor:

Buspar (Buspirone HCL) is a new anxiolytic that has a completely different chemical and pharmacological composition, not related to the benzodiazepine or any other anxiolytic agent.

The chemical composition is of AZASPIRODECANEDIONES and the characteristics of this product are that it does not produce psychomotor or cognitive impairment, does not potentiate CNS depressant, effect from alcohol, and does not possess apparent abuse liability or withdrawal symptom. It is well tolerated and has been on the market in Germany and other countries in Europe for the last two years and recently approved by the FDA.

The dosage use is of 5 mg. T.I.D., up to 20 mg. a day, and from my experience it is very well tolerated in patients that meet the criteria of anxiety set by the DSM-3, such as, promonate somatic or automatic symptoms — signs that will include increase of pulse, respiration rate, fidgeting, restlessness, jitteriness, gastrointestinal discomfort, dizziness and paresthesia.

Sincerely,
Enrique N. Kaufman, MD
Cincinnati

Editor's Note:
Ohio Medicine *regrets the error and any confusion that may have come about as a result.*

Opinions on drug testing

To the Editor:

In the last OSMAgram you talked about drug testing. My personal opinion is no one should be using drugs, including alcohol and tobacco. My professional opinion is that as long as people have the freedom to do as they please, what they do in private is their own business. However, when the effects of the activities carry over into the work situation or on the job, this poses a potential injury risk for the employer.

I feel, at the very least, drug testing would be appropriate for this injured employee and that this would disqualify him for any industrial compensation should he be found positive. Because the conduct or the ability of the employee is impaired with having a substantial blood level, this does pose a problem or risk for the company and the company should have the authority or recourse to prevent or control this.

John W. Zimmerly, MD
Jackson

Medicare payment suggestion

To the Editor:

This suggestion is from a patient's point of view — but it concerns equally both the physician and the third-party payor.

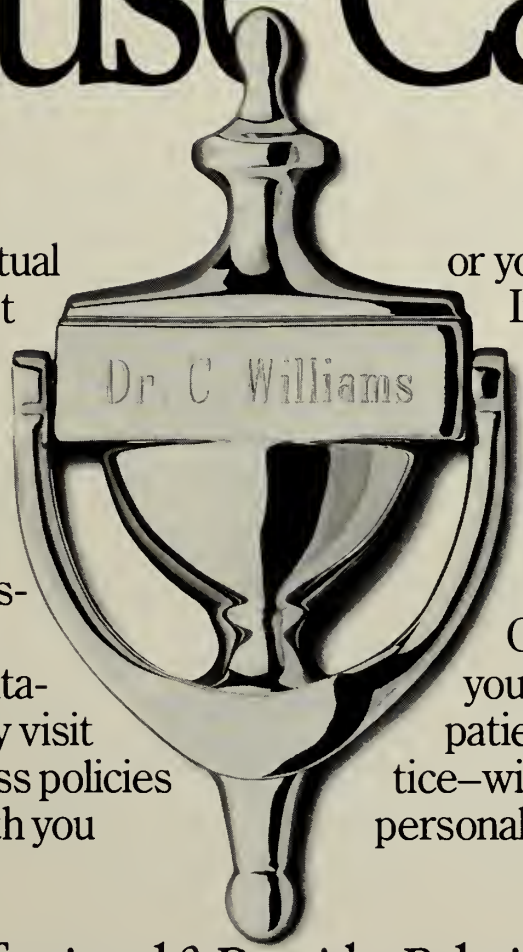
When I make my routine visits to my internist, he usually charges $22.00 per office call (plus other charges as indicated). His office bills my Medicare and Medifill, and, in time, his office gets a check for about $17.60 from one insurer, and, at a later date, I get a big voucher and a check for $4.40 from the other insurer. I sign the check and send it to my internist. This seems to me to be a Rube Goldberg procedure of secretarial effort. Why couldn't the two insurers keep in touch with each other — which should be easy enough in this age of the computer — and have a masterlist of *all* patients who have *both* insurances. (Of course, there might be more than one secondary masterlist; and they might be upgraded by computer on a daily basis.)

Then, the first insurance payor could pay the physician in full for what the insured owes him. At the end of a pay period — a week or a month — the first insurer would be compensated by the second insurer in one lump sum for all the hundreds or thousands of minor payments. Maybe I am just dreaming — maybe bureaucracy can't accomplish such simple things — but it sure would eliminate a lot of secretarial work and expense.

Henry Bachman, MD
McConnelsville

Address your "Letter to the Editor" to: OSMA, 600 S. High St., Columbus, Ohio 43215.

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Quality of Care: A Non-Negotiable Item

By Richard G. Orlando, MD

During my residency training (just three short years ago), competition was not a concept associated with health care. Physicians and hospitals had more than enough work to go around. Today, hospitals, physicians, and allied health practitioners are fighting like never before for a share of the patient population. At the same time, employers, the government, and insurance companies are dramatically changing the way costs are reimbursed. New health benefit packages with names like HMO, PPO, and IPA are being introduced and heavily promoted. Are these changes affecting the way we practice?

It seems that government health agencies and industry have become so concerned with cost containment efforts that it has become routine to withhold services and deny special tests that may aid in improving the quality of our patients' lives. A case in which I was recently involved demonstrates this. I was called to a local emergency room to evaluate a patient who had been hit by a softball. The patient had a hyphema, which had obscured the view of the internal part of the eye. He was in quite a bit of pain and the intraocular pressure was elevated. I admitted him overnight for treatment of the elevated pressure and for observation. By the next day, the bleeding had stopped inside the eye and his pressure had lowered. I discharged him and followed him up in the office a week later. A short time after being released from the hospital, the patient received a notice that his hopitalization would not be covered. It was decided that although this could have been an emergency, any admissions should have taken place at the hospital that the HMO contracted with. Transferring a patient with a hyphema across town could only cause further damage to an eye and turn the situation from one that called for medical treatment to a more serious surgical problem. Not only would this cost more money in the long run, but it could result in permanently reduced vision.

During my residency training, it seemed that the relationship between a physician and patient was based on a few simple criteria. The patient selected a physician based on recommendation of a friend, a referral by another physician, or by reputation. Today, this relationship is being threatened in the name of cost containment.

In some instances two physicians have found themselves at odds when caring for the same patient solely because of financial considerations. As an example, a patient was referred to me from an urgent care center recently for treatment of severe conjunctivitis. He was under an HMO plan that covered "emergency care," and, it being the weekend, he sought relief from a watery, painful pink eye. I saw him that Sunday morning and during the course of the exam found the patient to also have rather markedly enlarged optic nerves consistent with untreated glaucoma. After treating his conjunctivitis, I began to work up his glaucoma and had planned to begin treatment. During this time, a notice was sent from his HMO that since my services were not okayed by his "gate-keeper" physician, my services would not be reimbursed under his plan. I have talked to his physician and he informed me that he felt he could decide when and if the patient needs glaucoma therapy. Therefore, even though he had a complete work-up for glaucoma, his treatment has been delayed by bureaucratic entanglements. The patient has decided he will start treatment with me even though he will not be reimbursed since it is outside the HMO. It is my feeling that this type of manipulation and interference in patient care is against everything we stand for as physicians. Several of the new health plans have a physician as a so-called "gate-keeper," in which the primary care physician decides

continued on page 291

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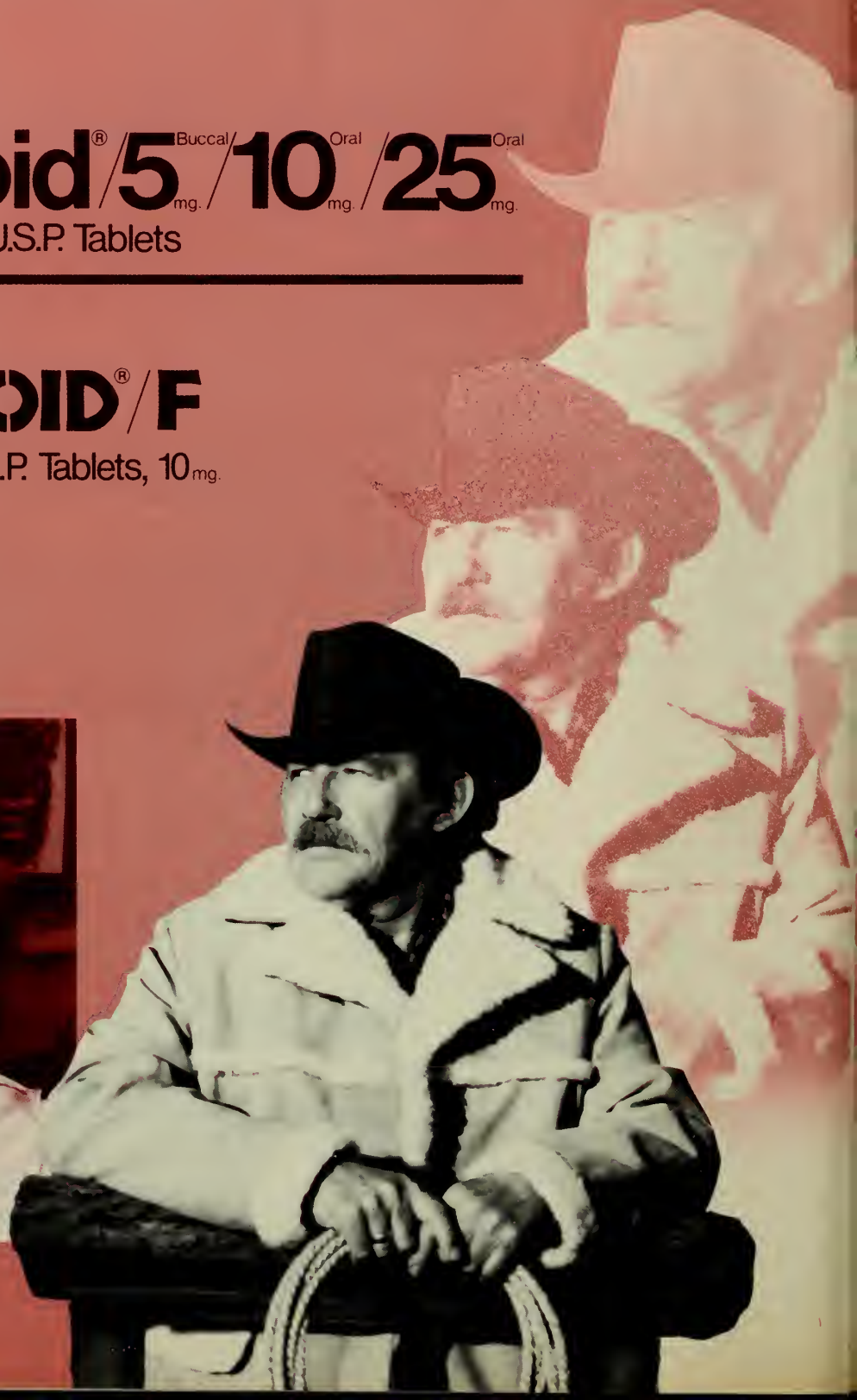
Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral

Methyltestosterone U.S.P. Tablets

ANDROID®/F

Fluoxymesterone U.S.P. Tablets, 10 mg.





"In the future, physicians must learn to work for the common good of their patients."

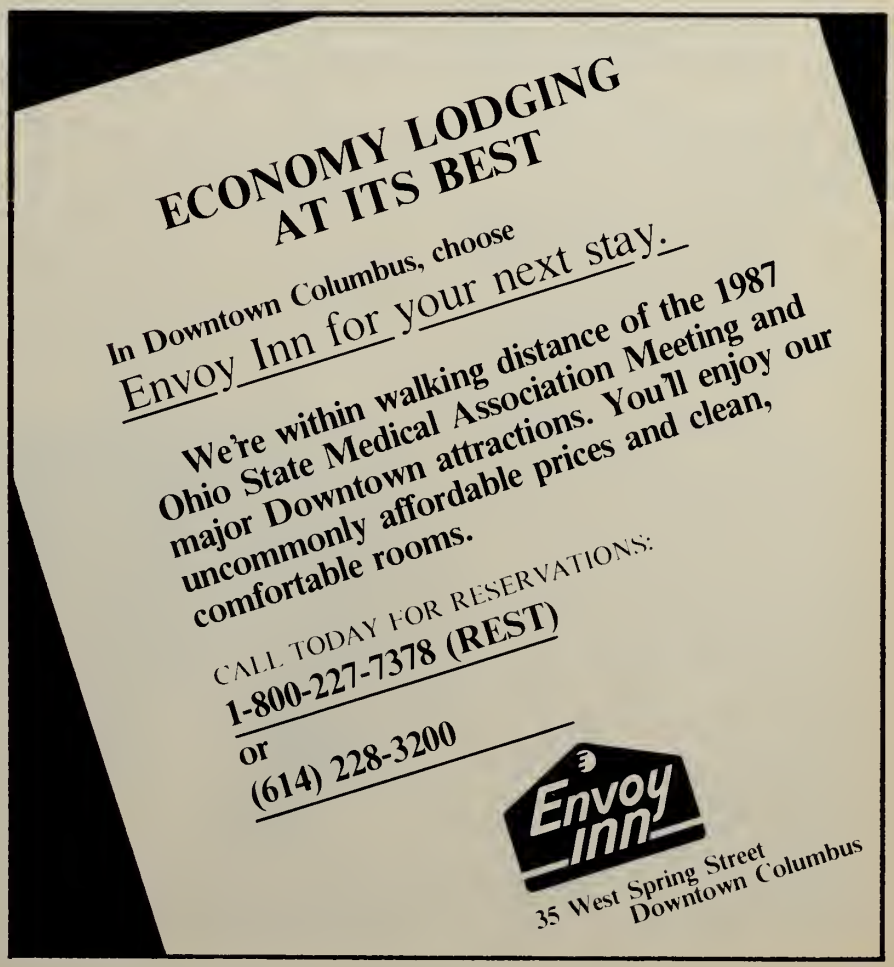
what treatment and referrals are "necessary." Many critics see this as a restriction of a patient's freedom of choice. As a specialist, I have found that many potentially serious problems have not been handled and referred in a timely matter, and that some patients are actually being harmed by such a system. They also are finding many of the "covered" services denied on a retroactive basis. This can put a severe financial burden on an unsuspecting patient.

In the future, physicians must learn to work for the common good of their patients. Combined medical and financial interests can cloud a physician's judgement and should never enter a clinical decision. I am all for healthy competition between physicians, since it challenges us to be the best at what we do. A closed panel HMO, however, stifles a patient's choice, and a specialist in such a system has a prescribed group of patients to draw on. The HMO could then contract out services based solely on who they can hire at the lowest price, rather than who delivers the highest standards of care. If one of our family members were seriously ill, would we refer them to whomever was the "lowest bidder"?

Interference by government and third party payers in medicine will continue. Both will continue to have a "bottom line" mentality and undoubtedly compromise care. We must let them know that quality of care is not negotiable and will not be rationed. We must inform our patients about how these alternative health care options work so that they can exert pressure on employers who use them. We can also ask pharmacies, allied health agencies, and medical facilities to provide patients of private physicians discounts similar to those given HMO clients in order to make medical care affordable to all. Physicians have to work harder as patient advocates and strive for the highest quality of care for all. **OSMA**

Richard G. Orlando, MD, is an ophthalmologist practicing in Dublin, Ohio.

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of Ohio Medicine *or the Ohio State Medical Association.*
Do you have a cause you would like to support? A grievance you wish to air? Why not write a "Second Opinion"? Send your contribution to: The Executive Editor, Ohio Medicine, 600 S. High St., Columbus, Ohio 43215.



OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians.



Cutting back on cholesterol

Serum cholesterol levels among US adults may be on the decline — which may lead to reduced risks for coronary heart disease, according to a *Journal of the American Medical Association* article.

"Age-adjusted mean serum cholesterol levels decreased . . . 3 to 4 percent between the 1960 to 1962 and the 1976 to 1980 surveys," reported researchers at the National Center for Health Statistics in Bethesda, Maryland.

While these decreases are "statistically significant," additional studies of high- and low-density cholesterol changes and the effects of diet and exercise are needed, the report suggested.

Nevertheless, "for each 1 percent reduction in serum cholesterol level, an approximate 2 percent decline in coronary mortality can be explained," Bethesda researchers pointed out.

Obsessive-compulsive disorders

Obsessive-compulsive patients have higher than normal rates of glucose metabolism in certain parts of their brains, according to a UCLA study in the *Archives of General Psychiatry.*

Researchers used positron emission topography to monitor glucose metabolism in the brains of 14 obsessive-compulsive patients, 14 normal controls, and 14 patients with depression. The obsessive-compulsive patients showed a significantly higher metabolism in the caudate nucleus and orbital gyrus, the researchers reported.

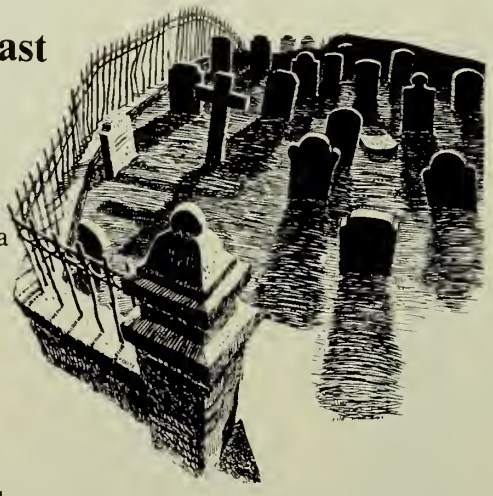
"Our findings do not address the cause of the disorder, but rather the neuroanatomic localization of the cerebral glucose metabolic processes that may mediate its expression," they stated.

Postscripts from the past

When Jefferson City, Missouri government officials recently microfilmed old government records, they found that cause-of-death reports from the 1800s left a lot to the imagination.

Reported in *American Medical News,* some of these historic medical diagnoses included:

- "Went to bed feeling well, but woke up dead."
- "Died suddenly, nothing serious."
- "Cause of death unknown; had never been fatally ill before."
- "Death caused by blow on the head with an ax. Contributory cause, another man's wife."



Metropolis

Ohio has been deemed a "first tier" high technology state, according to a researcher at the Institute for the Future, a California research and consulting firm.

The researcher described Ohio as "a leading employer in information services, medical equipment, computers and software," according to an article in *Business First.*

The findings were based on industry studies and figures from the US Commerce Department, and other technology manufacturing data.

Other states mentioned in the study include California, Massachusetts and New York.

Edited by Deborah Athy

Elderly abuse

Approximately 10% of America's elderly may suffer from some type of abuse, according to an AMA Council on Scientific Affairs report published in the *Journal of the American Medical Association.*

The report found that "one in every 25 elderly Americans may be victims of such abuse, representing an increase of approximately 100,000 abuse cases annually since 1981." The abuse may include neglect, emotional, verbal and physical abuse, and financial exploitation, among other things.

The AMA Council recommends that physicians should: identify those elderly who may have been abused; institute steps to prevent further injury; evaluate and treat injuries sustained through abuse; maintain objectivity; establish therapeutic alliance with family members; and comply with state statutes for reporting suspected abuse.

Liability woes

The nation's highest malpractice insurance premiums have forced some south Florida obstetricians and neurosurgeons into early retirement and others to refuse to perform some high-risk procedures, reports a *Florida Medicine Today* article.

Neurosurgeons and obstetricians in Dade and Broward Counties are paying $97,101 and $76,641, respectively, for annual insurance coverage — 50% more than these specialists pay in other parts of the country, according to the article.



The long and winding road

The following medical findings were compiled in a 1986 publication of the American Council on Science and Health. While these accomplishments represent only a fraction of 20th-century medical advances, they may serve as a reminder of how far medical ingenuity has come — and may also offer some hope for the future.

1900-1909
- Structure in pancreas related to diabetes (1901)
- Chromosomes are units of heredity (1902)
- First direct blood transfusion (1905)

1910-1919
- Some cancers caused by viruses (1910)
- Vitamins A & B isolated (1913)
- Process for storing blood (1916)

1920-1929
- Vented oxygen tent (1921)
- Vitamin E discovered (1922)
- Electric probe developed to burn away tissue — precursor of the laser (1928)

1930-1939
- Virus grown in chicken eggs opens door to vaccines (1931)
- Vitamin C isolated in lemon juice (1932)
- Congenital heart defect repaired (1938)

1940-1949
- Large-scale production of penicillin begins (1943)
- DNA is the genetic map responsible for heredity (1944)
- American Cancer Society and National Cancer Institute warn cigarette smoking may cause cancer (1949)

1950-1959
- Fluoridated water shown to reduce tooth decay (1951)
- Vaccine for poliomyelitis (1954)
- Plastic contact lenses (1954)

1960-1969
- Birth control pills made available to the public (1960)
- Measles vaccine developed (1963)
- America's first heart transplant (1968)

1970-1979
- Rabies vaccine developed (1973)
- National Cancer Institutes link cancer to pollution (1975)
- Cause of Legionnaire's Disease found (1977)

1980-present
- FDA approves vaccine against serum hepatitis (1981)
- AIDS virus identified (1984)
- Cyclosporines used to inhibit rejection in organ transplants (1985)

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OHIO MEDI-SCENE

Assessing nursing home care . . . the Radiological Society's guest speaker . . . Cincinnati's new "buckle-up" stickers . . . house calls for the mentally ill . . . Ohio's Medicaid Drug Formulary . . . the Americanism Foundation . . . physical signs of stress . . .

Assessing quality care in nursing homes

Recent census data show the fastest growing portion of the population in the United States is the 85 and older age group. And while many of those individuals remain healthy enough to live in their own homes or with family or friends, an increasing number of elderly need long-term care.

The demand for nursing home care is not just limited to the elderly. Following the implementation of the DRG reimbursement system for Medicare in 1984, greater numbers of hospital patients have been released too early to be able to take care of themselves in their homes. Thus, some nursing homes are now settings for short-term periods of recuperation and rehabilitation, as well as the long-term care traditionally offered in the nursing home facility.

All of this has resulted in a projected need for over 100,000 new nursing home beds over the next 10 years, according to Robert Burmeister of the Joint Commission on Accreditation of Hospitals (JCAH), who recently addressed the OSMA Committee on Geriatric Medicine. It has also led to problems in determining which facilities are capable of offering what types and kinds of services — and what is the quality of those services they are offering.

In addition to accrediting hospitals, the JCAH also offers an accreditation program for long-term care facilities, along with mental health facilities, ambulatory care centers and hospice programs. National standards of care are set for each of these areas and outlined in special manuals developed by the JCAH, which then applies these standards when conducting surveys and awarding accreditation to programs and facilities.



The program, however, is strictly voluntary, Burmeister points out. In fact, only 39 of Ohio's 400 nursing homes have sought and received accreditation from the JCAH, even though virtually all of Ohio's hospitals are JCAH accredited. What is the reason for the low compliance?

The first is cost, Burmeister admits. "The typical nursing home of 100 beds has to come up with $3,000 for the procedure," he says, which includes paying a field surveyor to evaluate quality assurance, care management and life safety (the physical plant and building inspection) in the nursing home.

While facilities are accredited for a three-year period,

OHIO MEDI-SCENE

Assessing quality care in nursing homes

continued

"the facility has to justify the expense, by weighing the value and benefits it will receive from being JCAH accredited," Burmeister says.

Due to the critical and growing shortage of beds, most nursing homes have little problem keeping their facilities full; thus, they don't really need a drawing card like JCAH accreditation to bring in more patients. "Usually the only questions asked are: is there a bed available in a timely fashion, will the family accept it and can they afford it," Watson Parker, MD, a member of the Geriatric Committee, pointed out at the meeting. Thus, issues of quality assurance are often left by the wayside, as patients scramble for a diminishing number of beds and nursing home care continues to rise in cost.

Perhaps the biggest reason nursing homes don't seek out the JCAH seal of approval is the fact that they already are regulated and must abide by state and federal criteria. Unlike hospitals, long-term care facilities cannot substitute JCAH accreditation for state and federal inspections and certification procedures — even though the JCAH survey and assessment is much more comprehensive and complete.

For example, the JCAH Standards Manual on long-term care examines a long list of services offered by nursing homes, including dental, dietetic, medical, nursing, rehabilitation, diagnostic, social and spiritual services. Surveyors also assess quality control, the governing body and management of the facility, the infection/control environment and patient/resident activities, rights and responsibilities.

"HCFA has done a complete review of Joint Commission standards and has found they meet or exceed all federal certification requirements," Burmeister says. "Our quality assurance standards are unique to JCAH's approach — there is no equivalent in the federal or state certification or licensure procedures."

Still, when attempts were made recently to allow nursing homes to use the JCAH accreditation program in lieu of federal and state inspections, the effort was thwarted by consumer groups and state agencies who lobbied against it. "They felt that an organization dominated by hospital administrators and doctors (such as the JCAH) would have a conflict of interest," Burmeister says. "Also at issue were the 2500 jobs that would be lost if state survey and certification processes were eliminated."

Perhaps the best solution, according to Burmeister, is "more collaboration between state regulatory and voluntary accreditation standards. One problem is that we don't sit around enough tables and realize we have many of the same concerns and goals." — *Susan Porter*

Ohio State Radiological Society Annual Meeting

May 9, 1987

Herman D. Suit, MD

Featured Guest Speaker — Radiation Oncology Session

Herman Day Suit received his MD from Baylor University and PhD in Radiobiology from Oxford University in England. He was a staff radiotherapist and chief of the section of experimental radiotherapy at the MD Anderson Hospital in Houston, Texas from 1959 to 1970, and has been professor of radiation therapy at Harvard Medical School and Massachusetts General Hospital since 1971. He was President of the American Society of Therapeutic Radiology and Oncology in 1981, and of the Radiation Research Society in 1987. In 1986, he became the first Andres Soriano Professor of Radiation Oncology at Harvard. In April, 1987, he will give the Janeway Lecture, the most prestigious lecture of the American Radium Society, at the Annual Meeting in London, England. One of the three presentations he will give to the annual meeting of the Ohio State Radiological Society in Dayton on May 9 will be a recapitulation of the Janeway Lecture.



Cincinnati Academy reminds drivers to buckle up

"What's holding you back?" asks the boldly designed red, white and blue stickers which the Academy of Medicine of Cincinnati recently had printed as tangible reminders to Hamilton County drivers and passengers to "buckle up" inside their cars.

The stickers are meant to be placed on windshields or dashboards to remind those inside that seat belts are six times as effective in preventing serious injury and 50 percent more effective in preventing death. They are currently being distributed free by all Hamilton County deputy registrars to drivers purchasing or renewing car license tags.

The project was suggested by Academy member John Loughrey, MD, after a guest on his former TV show, "Call the Doctor," spurred him to post a handmade reminder in his car. When he succeeded in changing his own behavior, he recommended it to the Academy Communications Committee.

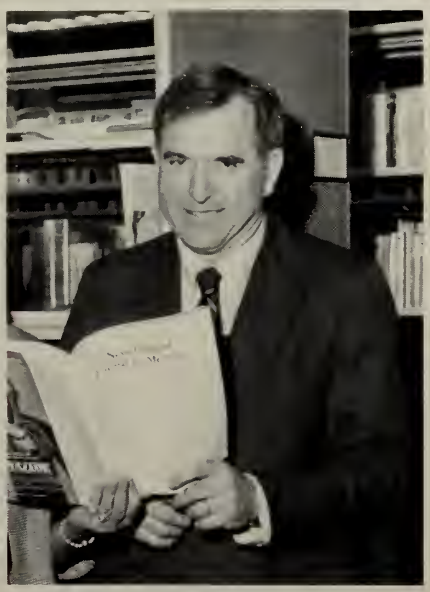
"This public education effort demonstrates the Academy's commitment to the health and safety of the community," says Dr. William C. Miller, chairman of the Academy Communications Committee.

The stickers were produced with the endorsement of the Ohio Department of Highway Safety, the National Highway Traffic Safety Administration and the Cincinnati Auto Club. — *Karen S. Edwards*

JAMA's freedom of the press ...

In the December, 1986 issue of the *Ohio State Medical Journal,* "So You Want to Edit the NEJM . . .," Dr. Arnold Relman, editor of the *New England Journal of Medicine,* was quoted as saying that because *JAMA* is the publication of the AMA, it is not free to publish views opposite those of the AMA. Officials of *JAMA* disagree. The editorial content of *JAMA* and the nine specialty articles are determined by the editor and the editorial board, irrespective of official policies, they say; and, in fact, after appropriate peer review, *JAMA* frequently publishes articles which disagree with AMA policy.

Dr. Relman is pictured at right.



House calls for the mentally ill

Franklin County's Mental Health Board will be treating approximately 750 severely mentally ill people at home and on the job, instead of at a community center, reports a news story printed in the *Columbus Dispatch.*

The program, modeled after one in Madison, Wisconsin, will offer counseling, medication follow-ups and other help to the chronically mentally ill through five teams, made up of mental health counselors, social workers and psychiatric nurses. The five-member teams will help patients find employment and will visit them on the job to help them better fit into the workplace. Team members, who will carry caseloads of 30 patients per month, will also be on call 24 hours so that a patient in crisis can receive immediate assistance — including hospitalization if necessary.

It is hoped that the new program — funded by a $2.5 million grant from the Robert Woods Johnson Foundation of Princeton, New Jersey — will cut down on the number of repeated hospitalizations for these patients.

"This is the most major philosophical change in mental health in years," Franklin County Mental Health Board President Jonathan L. York was quoted as saying. It is, in fact, a modification of the community health care movement of the 1960s and '70s, which saw the deinstitutionalization of thousands of mental health patients.

The grant will also allow the board to purchase and renovate an apartment building to house the chronically mentally ill. Rent subsidies for 125 private apartments for patients will be provided by the Department of Housing and Urban Development.

Toledo and Cincinnati were among the nine cities nationwide to receive similar Johnson foundation grants. — *Karen S. Edwards*

OHIO MEDI-SCENE

The Ohio Medicaid Drug Formulary

OHIO DEPARTMENT OF HUMAN SERVICES ANTIHISTAMINES, DECONGESTANTS, EXPECTORANTS, ANTITUSSIVES COVERED DRUGS EFFECTIVE MAY 1, 1987

This list represents those drugs that are presently covered in the Ohio Medicaid Drug Program. Many drugs will be deleted April 30, 1987 and thus are not included in this list. They include most notably Polaramine, Periactin, Optimine, Tyzine, Novafed, Hycodan, Organidin, Histaspan D, Rynatan, Ambenyl, Tussends, Hycomines Adult, Nucofeds, Tussi-Organidins, Hycotuss and Triaminics.

Expenditures for these four drug categories in 1986 totaled $3,136,954 for 396,100 prescriptions or an average of $7.92 per prescription. During the course of 1986 the department undertook elaborate measures to determine whether savings could be effected in these categories. The Pharmacy and Therapeutics Committee proposed many changes, and, with the assistance of the Ohio State Medical Association and the Ohio Osteopathic Association, the opinions of some 780 physicians were solicited. The enclosed formulary represents the consensus of their responses and the committee's adaptation of those responses.

Every effort has been made to satisfy the following objectives: maintain essential health care of recipients, provide physicians adequate options to prescribe for that care, provide pharmacists readily available products to dispense for that care, and be cost-effective.

If a product that you have been prescribing is not listed, the Ohio Department of Human Services is confident that you can select a suitable alternative product from this formulary. Prior authorization for non-formulary drugs will only be granted when it can be documented that the desired medical response is not attainable with these alternatives.

For your convenience the products are listed by therapeutic category and, within each category, *generally listed in average cost-per-day ascending order.*

Thank you for your cooperation in this endeavor to provide quality health care to Medicaid recipients at minimal cost to the taxpayers of Ohio.

I. ANTIHISTAMINES

CHLORPHENIRAMINE MAL
4MG, 8MG, 12MG, SYRUP

BROMPHENIRAMINE MAL
4MG, 8MG, 12MG, ELIXIR

DIPHENHYDRAMINE HCL
25MG, 50MG, ELIXIR

DEXCHLORPHENIRAMINE
4MG, 6MG, SYRUP

TRIPROLIDINE HCL 2.5MG,
SYRUP

NOTE: For your reference the following abbreviations are used:

AZATADINE	**AZAT**
BROMPHENIRAMINE	**BROMPHEN, BP**
CARBETAPENTANE	**CARBET**
CARBINOXAMINE	**CARB**
CHLORPHENIRAMINE	**CHLORPHEN, CTM**
CLEMASTINE	**CLEM**
CODEINE	**COD**
DEXBROMPHENIRAMINE	**D-BROMPHEN, DBP**
DEXTROMETHORPHAN	**DM**
EPHEDRINE	**EPH**
GUAIFENESIN	**GUAI**
HYDROCODONE	**HYDROCOD, HY**
PHENINDAMINE	**PHENIN**
PHENIRAMINE	**PHEN**
PHENYLEPHRINE	**PHEN-E**
PHENYLPROPANOLAMINE	**P-PROP, PHENYLPROP**
PHENYLTOLOXAMINE	**P-TOL**
PROMETHAZINE	**PROM**
PSEUDOEPHEDRINE	**PSEUDOEPH, PSEUDO, P-EPHED, PE**
PYRILAMINE	**PY**
TRIPROLIDINE	**TRIPROL, TP**

CYPROHEPTADINE 4MG, SYRUP
PROMETHAZINE 12.5MG, 25MG, 50MG, SYRUP
TRIMEPRAZINE SYRUP
PHENERGAN 12.5 MG, 25MG, 50MG
TEMARIL 2.5MG, 5MG, SYRUP
TACARYL 3.6MG, 8MG
TAVIST 1.34MG, 2.68MG, SYRUP

II. DECONGESTANTS
PSEUDOEPHEDRINE 30MG, 60MG, SYRUP
PSEUDOEPHEDRINE 120MG SA CAP
PHENYLEPHRINE NASAL SOLN 0.12%, 0.25%, 1%
SODIUM CHLORIDE NASAL SOLN, SPRAY

III. ANTITUSSIVES
DEXTROMETHORPHAN COUGH SYRUP
HYDROCODONE BITART SYRUP
DELSYM LIQUID (DEXTROMETHORPHAN)
TESSALON PERLES

IV. EXPECTORANTS
GUAIFENESIN SYRUP
IODINATED GLYCEROL SOLN, DROPS
HYDRIODIC ACID SYRUP
POTASSIUM IODIDE SATD SOLN, 300MG TABS
NORISODRINE W/CALCIUM IODIDE SYRUP

V. ANTIHISTAMINE-DECONGESTANT COMBINATIONS
BROMPHEN, P-PROP TAB, ELIXIR
P-PROPANOLAMINE HCL, CHLORPHEN CAP
D-BROMPHEN, PSEUDOEPH TR TAB
CHLORPHEN, PSEUDO TAB, SYRUP
TRIPROLIDINE W/PSEUDOEPHEDRINE TAB, SYRUP
NALDELATE TAB, SYRUP (CTM, P-TOL, PHEN-E, P-PROP)
DIHISTINE ELIXIR (CTM, PHEN-E)
CARBODEC SYRUP (CARB, PE)
PROMETHAZINE VC SYRUP (PROM, PHEN-E)
EXTENDRYL SR CAP (CTM, PHEN-E)
RHINEX D-LAY TAB (CTM, P-PROP)
CODIMAL LA CAP (CTM, PE)
FEDAHIST GYROCAP (CTM, PE)
DRIZE CAP (CTM, P-PROP)
PHENERGAN D TAB (PROM, PE)
RUTUSS II TAB (CTM, P-PROP)
COMHIST LA CAP (CTM, P-TOL, PHEN-E)
DIMETAPP EXTENTAB, ELIXIR (BP, P-PROP)
CORSYM SYRUP (CTM, P-PROP)
NOVAFED A CAP (CTM, PE)
RONDEC SYRUP (CARB, PE)
RONDEC TAB, TR TAB (CARB, PE)
TRIAMINIC TR TAB (PHEN, PY, P-PROP)
NOLAMINE TAB (CTM, PHENIN, P-PROP)
SINGLET TAB (CTM, PHEN-E)
COMHIST TAB (CTM, P-TOL, PHEN-E)
DECONAMINE SYRUP, SR CAP, TAB (CTM, PE)
ISOCLOR TAB, TIMESULE, LIQUID (CTM, PE)
TRINALIN TAB (AZAT, PE)
TAVIST D TAB (CLEM, P-PROP)
ORNADE CAP (CTM, P-PROP)

VI. ANTIHISTAMINE-ANTITUSSIVE COMBINATIONS
PROMETHAZINE DM SYRUP
PROMETHAZINE CODEINE SYRUP
BROMPHENHYDRAMINE CODEINE SYRUP
PENNTUSS LIQUID

VII. DECONGESTANT-ANTITUSSIVE COMBINATIONS
HYDROCODONE, P-EPHED SYRUP
HYDROCODONE, P-PROP SYRUP

VIII. DECONGESTANT-EXPECTORANT COMBINATIONS
PHENYLPROP, GUAIFENESIN LA TAB
CONGESS JR CAP (PE, GUAI)
CONGESS SR CAP (PE, GUAI)
RESPAIR SR 60MG, 120MG CAP (PE, GUAI)
ENTEX CAP (PHEN-E, P-PROP, GUAI)
ENTEX LA TAB (P-PROP, GUAI)

IX. ANTITUSSIVE-EXPECTORANT COMBINATIONS
GUAIFENESIN, DM SYRUP
GUAIFENESIN, CODEINE SYRUP
IODINATED GLYCEROL, DM SYRUP
IODINATED GLYCEROL, CODEINE SYRUP
CODICLEAR DH SYRUP (HY, K-GUAI)
DILAUDID COUGH SYRUP (HYDROMORPHONE, GUAI)

X. ANTIHISTAMINE-DECONGESTANT-ANTITUSSIVE COMBINATIONS
PROMETHAZINE VC CODEINE SYRUP
TRIPROL/PSEUDO/CODEINE SYRUP
BAYDEC DM OR CARDEC DM SYRUP (CARB, PE, DM)
DIHISTINE DH SYRUP (CTM, PE, COD)
BROMPHENIRAMINE MAL DX SYRUP (BP, PE, DM)
BROMPHENIRAMINE DC EXP (BP, P-PROP, COD)
CODIMAL DH SYRUP (PY, PHEN-E, HY)
DIMETANE DC SYRUP (BP, P-PROP, COD)
DIMETANE DX SYRUP (BP, PE, DM)
RUTUSS/HYDROCODONE LIQUID (PY, PHEN, P-PROP, PHEN-E, HY)
ACTIFED CODEINE SYRUP (TP, PE, COD)
RONDEC DM SYRUP (CARB, PE, DM)
RYNATUSS TAB (CTM, PHEN-E, EPH, CARBET)

XI. DECONGESTANT-ANTITUSSIVE-EXPECTORANT COMBINATIONS
DIHISTINE EXP (PE, DM, GUAI)
HYDROCOD, P-EPHED, GUAI EXP
RUTUSS EXPECT (PE, DM, GUAI)

OHIO MEDI-SCENE

Ohio Medicaid Drug Formulary . . . *continued*

NOVAHISTINE DMX EXP (PE, DM, GUAI)
DONATUSSIN DC SYRUP (PHEN-E, HY, GUAI)

XII. PEDIATRICS
PEDIACARE-1 LIQUID (DM)
BAYDEC DM OR CARDEC DM DROPS (CARB, PE, DM)
HYDROCOD, P-EPHED PED SYRUP
NALDELATE PED SYRUP (CTM, P-TOL, PHEN-E, P-PROP)
EXTENDRYL CHEWABLE, JR (CTM, PHEN-E)
PEDIACARE INFANT DROPS (PE)
ENTEX LIQUID (P-PROP, PHEN-E, GUAI)
NUCOFED PED EXP (PE, COD, GUAI)
RYNATAN PED SUSP (CTM, PY, PHEN-E)
PEDIACOF SYRUP (CTM, PHEN-E, COD, KI)
NALDECON EX DROPS (P-PROP, GUAI)
NALDECON PED SYRUP (CTM, P-TOL, PHEN-E, P-PROP)
CORILIN DROPS (CTM)
NALDECON PED DROPS (CTM, P-TOL, PHEN-E, P-PROP)
HYCOMINE PED SYRUP (P-PROP, HY)
RYNATUSS PED EXP (CTM, PHEN-E, EPH, CARBET)
RONDEC DROPS (CARB, PE)
RONDEC DM DROPS (CARB, PE, DM) — *Robert Reid, pharmacist, Columbus; Janet A. Bixel, MD, Columbus.*

OSMA receives membership award



D. Ross Irons, MD (right), OSMA's President-Elect, accepts, on behalf of the OSMA, the 1986 membership award from William Hotchkiss, MD, President-Elect of the American Medical Association. The plaque, presented at the National Leadership Conference, was awarded to the OSMA for exceeding its tenth consecutive year of AMA membership.

The Americanism Foundation

It reads something like a Charles Dickens story: a young orphan rises above his circumstances and overcomes a multitude of obstacles to achieve his lifelong goals.

When Nino Camardese, MD, immigrated to the U.S. from Italy in 1939, he was a 13-year-old orphan who couldn't speak a word of English. But years of determination and persistence paid off; in 1953 he received his MD degree from the OSU College of Medicine and began a family practice in Norwalk. Last year, he was named Ohio's Outstanding Naturalized American Citizen by Governor Richard Celeste.

In addition to his medical practice and a many-tiered and longstanding involvement in the community and in medical organizations, Dr. Camardese is president of the Americanism Foundation, which he spearheaded the establishment of in 1979.

The Americanism Foundation offers a variety of patriotic programs for high school students, teachers and the community-at-large, and is "a new way of boosting Americanism," explains Dr. Camardese.

The overall purpose of the foundation is to "foster the fundamentals of freedom, responsibility, productivity, citizenship, free enterprise, and our great American heritage and legacy of freedom," he continues.

One means to this end has been a program designed to pass on these principles to America's youth, by offering seminars, speeches and essay contests for high school students.

In February and March 1987, foundation speakers spoke with more than 2,300 high school students and 500 grade school students. Recent speakers included a Nicaraguan journalist; a professional runner who defected from Poland; and a Russian immigrant who now lives in Toledo. Dr. Camardese adds that the foundation is available to make presentations to high school assemblies across the state.

A common theme espoused by these speakers — and one of the foundation's key themes as well — is that "Americans take freedom too much for granted."

In addition to the student programs, the foundation produces a number of informational pamphlets and schedules lectures all across the country addressing topics such as patriotism, patient education, bereavement, and American youth. Dr. Camardese also hosts a weekly radio program, "The Americanism Forum," which is broadcast over 80 stations in the US and in some foreign countries.

The foundation's message echoes a sentiment by the late President Kennedy: "Ask not what your country can do for you, but what you can do for your country."

To Dr. Camardese, this message still rings true. "Freedom is everyone's responsibility," he points out, which explains why he is interested in stirring up a more vital and visible physician participation in the foundation.

"I believe profoundly that physicians have a unique, great and unusual potential to influence the turn and direction of our great country through their local community leadership, involvement and influence" — particularly through involvement with youth, he says.

Thus far, Huron, Erie and Mahoning County Medical Societies have participated in some of the foundation's activities and events. Dr. Camardese urges other county medical societies, hospital medical staffs, and individual physicians to follow suit.



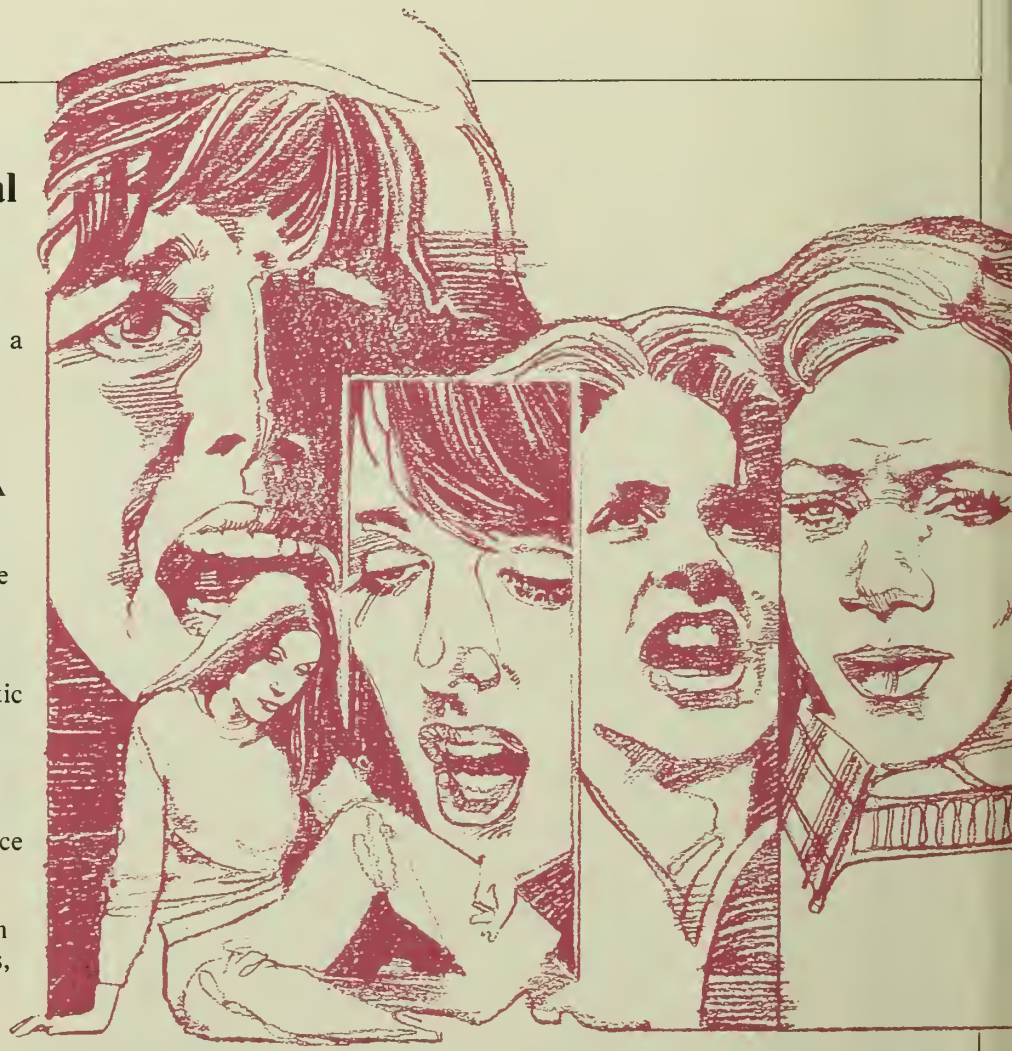
Nino Camardese, MD, above, an Italian immigrant, established the Americanism Foundation in 1979.

A quote by Edmund Burke, which is imprinted on the foundation's stationery, capsulizes why Dr. Camardese believes so fervently in immediate and united action to preserve this country's freedom: "The only thing necessary for the triumph of evil is that good men do nothing."

For more information about the foundation and its programs, write the **Americanism Foundation**, Norwalk, OH 44857; or call (419) 668-8282.

OHIO MEDI-SCENE

Examining the physical side of stress



For years, primary care physicians have known that a number of their patients suffer from more than just the headaches, stomach pains, backaches, indigestion and other general symptoms they present. A conservative estimate is that over 50% of the patients who come into a general practitioner's office suffer — at least in part — from symptoms related to stress, while as many as 90% of all physical illnesses may have a psychosomatic component.

"This is not to say these problems are all in the patients' minds," says Stephen P. Flynn, MD, who heads the family practice residency program at Fairview General Hospital in Cleveland. "These are very real diseases with very real symptoms: heart attacks, ulcers, migraine headaches, common colds and infections — perhaps even cancer. Illness is caused by many factors, often occurring together, but frequently, somewhere in that mix of causes is stress."

It is for this reason that the physical sides of stress, along with stress management techniques, are increasingly being emphasized in the formal training of medical students and residents in family practice. "There are now 22 family practice residency programs in Ohio," says Dr. Flynn, "and all include a good baseline in behavioral medicine. More and more, a bio-psycho-social approach or model is being incorporated into the family medicine curriculum."

Among the physiological effects of stress studied are changes in brain chemistry, hormonal secretions, the autonomic nervous system, the digestive tract and the immune system. New physicians also learn to help patients identify stressors — those events which precipitate stress in an individual — and to develop new and better mechanisms for coping with stress in their lives.

"All patients suffer from stress," Dr. Flynn points out. "Stress is a problem no one is spared until death." In fact, "some stress is necessary for healthy, personal growth," Dr. Flynn continues. "People with little or no stress are often bored and in a rut." The problems arise, however, "when the amount of stress exceeds the patient's ability to cope — then symptoms and illness may develop."

The physical symptoms of stress range from general, overall feelings of fatigue or anxiety, to peptic ulcers, high blood pressure and coronary artery disease. Frequently, patients suffering from chronic stressful conditions will complain of vague and general symptoms: backaches, headaches and stomachaches, says Dr. Flynn. "Nothing shows up in an exam or test — yet you know something is wrong."

Unfortunately, with more serious conditions — heart attack, stroke, etc. — physicians are so busy treating the physical side of the disease that they may ignore the psychological and emotional components. And with vague, nonspecific complaints, such as fatigue or anxiety, the patient may simply be assured that nothing is wrong — until a more serious problem develops.

Stress affects the body chiefly through three mechanisms, Dr. Flynn points out: the nervous system, the endocrine system and the immune system. In addition, there are three different stages of stress: the alarm stage, which is generally a primitive response of the body to a perceived threat; a resistance stage, wherein the body struggles to maintain function in the face of ongoing stressors; and the exhaustion stage, at which point the body's reserves are depleted and illness may develop.

Those suffering from the initial alarm stage of stress will experience increase in heart rate, blood pressure, muscle tension, blood tension, blood sugar, blood clotting, etc. — but these tend to disappear once the perceived threat is gone. Ongoing daily stressors — problems at home or work, deadlines, financial difficulties, etc., are more likely to produce more nonspecific symptoms, such as fatigue, shakiness, lack of concentration, poor memory and minor aches and pains. After a period of time, however, these stressors, along with major life events: a death in the family, the loss of a job, a divorce, etc., can lead to a stage of exhaustion, evidenced physically by ulcers, migraine headaches, infections, heart disease, etc.

"Stress is one of only many factors," Dr. Flynn is careful to state. "For example, heart disease is associated with hereditary factors, cigarette smoking, hypertension, elevated cholesterol and lack of exercise — as well as stress. And certainly, these diseases can occur without excess stress in our lives."

Still, the effects of stress on the body should not be underplayed, he says. "Also, remember that not only can stress precipitate illness, but illness — especially chronic illness — can create a considerable amount of stress in a person's life," he says. "This then creates a vicious cycle of stress and illness in a family."

Thus, residents in family medicine at Fairview General are now urged to look for a stress component in all of their patients, according to Dr. Flynn. In taking histories, residents question patients about those events likely to precipitate stress: social interactions with family and friends, losses in their lives and hassles of daily living, as well as the physical manifestations of their disease.

While stress is an essential component in daily living, it does not have to be disabling. "The stress response can be modified at several stages," Dr. Flynn points out.

For example, patients who are suffering from excess stress due to a major life event, such as the death of a loved one or a divorce, can be discouraged from making other major life changes — such as buying a new home or changing jobs — until they have learned to cope with their problem. Those suffering from ongoing pressures can rearrange their schedules to allow for more time for relaxation and personal satisfaction: cut down on meetings, avoid rush hour traffic and stay away from unpleasant social interactions, when possible.

Individuals can also learn to change their perception of an event in order to alleviate stress. "The loss of a job may be seen as a disaster, or as an opportunity to find more satisfying or creative work," Dr. Flynn explains. "It's the proverbial question of the cup: is it half empty, or half full?"

Individuals can also learn to strengthen their personal resources to deal with stress. This includes developing better coping skills, such as problem solving skills, the expression of emotions in constructive ways, the development of personally satisfying hobbies and recreational activities, and the use of aids such as relaxation response, biofeedback, yoga, meditation and prayer.

Also, patients should be encouraged to re-evaluate their attitudes and values in order to put some stressors in a better perspective. By asking the question, "What would you do if you had only six months to live?," priorities can be established and the stress caused by minor problems can be alleviated.

Studies show, says Dr. Flynn, that individuals who have an inner sense of control over their lives, are better able to cope with stress, while those who feel like a "cork in the ocean — always the victim of external forces" — lead more stressful lives. In addition, those who are flexible in their attitudes and lifestyles have fewer problems adapting to change, while those set in their ways see change as a threat and thus suffer from more stress.

In some cases, a major reduction in stress and its physical symptoms may only occur with some basic changes in personality, says Dr. Flynn. Those who have a strong "Type A" personality, for instance — marked by hostility, aggressiveness, compulsiveness, time urgency and eventually burnout — may have to learn to "stop and smell the roses" before a comfortable sense of balance can be reached in their lives.

"Personality characteristics can be ingrained, but they are changeable."

"Personality characteristics can be ingrained," Dr. Flynn points out, "but they are changeable. However, this requires intense intervention to modify, along with a lot of help from family and friends."

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Examining the physical side of stress . . . *continued*

In these cases, physicians might want to refer patients to psychiatrists or other mental health professionals who can help these patients modify their personality, behavior and lifestyle.

Less stressful lives — and thus healthier lifestyles — can also result from a sense of purpose and commitment, along with spiritual values, be they religious beliefs or simply "the concept that there is more than a material life," says Dr. Flynn. Those who are able to view life as more than just a series of daily non-related events can more easily disregard those stressors that are not really important to the overall scheme of things.

"If you can view daily life crises in the context of what they will mean two weeks or six months down the road — will anyone even recall that this event happened — then you are less likely to overreact and suffer from unnecessary stress," says Dr. Flynn.

Coping mechanisms are also enhanced by social supports: family and friends, community agencies, churches and physicians willing and able to help if there is a problem. For all of these reasons, physicians need to learn to recognize the physical signs of stress in their patients and to take these into account when making a diagnosis and planning a treatment program. Otherwise, these same patients will reappear in the physician's office again and again.

Physicians need to learn to recognize the physical signs of stress.

"You may be able to treat one symptom successfully," says Dr. Flynn. "But if the stress is still there, it will just resurface somewhere else." — *Susan Porter*

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RESTROOM

Drug Testing — How Well Is It Working?

By Susan Porter

At first glance, it looks like a sound concept — an easy solution to a problem that appears to be claiming more and more American workers, athletes, military personnel, health care workers and countless other individuals each year. You have all of your employees or team members or enlisted personnel or office staff take a simple urine test — the results of which are quickly analyzed at a nearby lab and on your desk a few days later. The test, when properly administered and confirmed, will tell you who's been smoking marijuana or sniffing cocaine or shooting heroin and who has not. At this point, you can separate the wheat from the shaft — give the non-users a pat on the back and, at the same time, reprimand the users, pointing them in the direction of a good rehabilitation program — or, in some cases, the door.

Despite the legal, ethical and financial ramifications of mass scale programs, drug testing through urine analysis seems like a simple answer to the drug crisis today's society faces. In fact, it is this very simplicity that concerns many of those working on the front line to combat substance abuse. Even the strongest advocates of drug testing will admit that to be truly useful, it must be viewed as just one component of a comprehensive substance abuse prevention and treatment program.

"The problem that we face is the cultural problem of substance abuse," says Edward T. Carden, MD, director of substance abuse programs for MEDNET/Euclid Clinic Foundation in Cleveland and vice chairman of the OSMA Physician Effectiveness Program. Dr. Carden was among a panel of professionals who addressed the pros and cons of drug testing at a special public forum sponsored by the OSMA in March. "Biological fluid testing is only one small part of it," Dr. Carden says, pointing out that complex concepts like impairment, addiction and human suffering cannot be measured in a test tube.

In addition, drugs that can be measured through a standard urine analysis are only a small part of the addiction problem today's society faces. "Alcoholism is responsible for more human misery than any other disease in our country," Dr. Carden points out. But the use of alcohol is not detected in a urine test given several hours after the exposure, leading Dr. Carden and others to comment, "Instead, the money (used for drug testing) should be going into cultural education" to combat the problems of drug and alcohol addiction on a variety of levels.

Still, drug testing is being used today by a variety of proponents who say it is having remarkable results within their organizations. To date, the federal government, under the orders of President Ronald Reagan, is the largest conductor of mass drug screenings — using them not only to screen out drug use among military personnel, but also among certain civilian employees in "critical" or "sensitive" positions, such as classified information and national security.

"For the past six years, the Department of Defense has seen a dramatic turn-around in internal drug use," says Lt. General Stephen G. Olmstead of the

"Substance abuse is a contagious disorder. If a few are using it, it will grow in the workplace."

United States Marine Corps and Director of the Department of Defense, Task Force on Drug Enforcement. "Back in 1980, we blindly did not feel that we had much of a drug problem — until an outside survey showed 47% (of those in certain ranks) admitted to using drugs. We didn't believe it, so we did our own survey. Ours showed 49% admitted to using drugs."

At that time, says Lt. General Olmstead, the Department of Defense was forced to face the fact that "we have a large group of people who are very vulnerable to drugs for a long period of time." The Department thus issued a strict "tough love" policy against drug abuse, warning enlistees to shape up or ship out. Part of that program includes mass urine screenings of all military personnel which now cost the U.S. government $180 million per year. But the results have been worth it, Lt. General Olmstead believes. "Current admitted use is now down to 9%," he reports.

"Our concerns are for safety and national security," he explains the program which last year included the analyses of some 2.3 million urine samples from all divisions of the armed forces and this year will be expanded to workers in a number of other federal agencies. "Most people recognize the necessity of it. Not many of us want to get in a helicopter if the mechanic has been stuffing something up his nose."

Safety and security are also reasons why Westinghouse Electric in Pittsburgh, Pennsylvania conducts regular drug screenings among key personnel — particularly those working in a Westinghouse subsidiary which services nuclear power plants. The tests, according to E. Carroll Curtis, MD, corporate medical director at Westinghouse, are "designed to protect the responsible majority from the irresponsible." He is quick to add, however, "Prevention and quality intervention are our best tools, although screening and rehabilitation are necessary at times."

Not all Westinghouse employees are screened for drug use. Those who work in less high-risk areas are tested only if there is reason to believe they are using drugs — "to confirm observations and other data." The biggest thrust of the Westinghouse program, says Dr. Curtis, is training supervisors to recognize the signs of drug and alcohol abuse and impairment, so that they might intervene and refer the individual to counseling and rehabilitation programs supported by the company.

"Our major concern is fitness for duty," says Dr. Curtis, adding that employees "high" on drugs and alcohol not only threaten themselves, fellow employees and the company, but they also hamper American business's ability to compete effectively in the world market. "The chief means to ensure such fitness is good supervision," says Dr. Curtis. "There is no substitute for conscientious observation, documentation and reprimand when performance is declining or poor," he says.

Yet some supervisors, particularly those over the age of 40, "don't know what marijuana looks or smells like" or may not be able to verify that an individual is regularly using cocaine over a lunch break — although signs of intoxication or use may be there. In these cases, a urine screening may be requested to confirm such a suspicion.

In addition, all job applicants are subject to drug and alcohol screenings in order to avoid future problems with drugs in the workplace. "Substance abuse is a contagious disorder," he says. "If a few are using it, it will grow in the workplace." Drug addicts looking for ways to support their habit will earn extra money "dealing drugs with fellow employees or stealing — and the employer is always a favorite victim," he explains.

Thus, drug testing is not only a method to confirm exposure to a drug — it is also an effective deterrent, both Dr. Curtis and Lt. General Olmstead believe. Because tests are unannounced, employees never know when samples are to be taken — so they soon learn that weekend or home drug use is as risky as substance abuse on the job, since signs of use can remain in their system for days.

Perhaps one of those most convinced that drug testing can be a successful deterrent to drug use in a select group of individuals is Robert J. Murphy, MD, chairman of the National Collegiate Athletic Association (NCAA) Committee on Drug Education and Head Team Physician at the Ohio State University. The NCAA, says Dr. Murphy, has sponsored various types of drug education programs since 1979 with the hopes of

solving the drug problem among college athletes. However, "in truth, very little of what we do in education appears to have much effect on those already using marijuana and cocaine," he says.

At the Ohio State University, an intensive drug education program was initiated in 1979 under the leadership of head football coach Earl Bruce, among others. "We brought in all types of professionals, experts on the subject and even former drug abusers," Dr. Murphy explains. "Because we had heard that large group presentations were ineffective, we divided the athletes into groups of 20 to allow for more interplay and one-on-one interaction. We also had a standing core committee to help athletes with their problems. We felt we had a good program at this point."

In 1984, however, "after five years of serious drug education, we suddenly realized that we still were not touching that 20% of the athletes who were involved in drugs," says Dr. Murphy. "You can provide speakers, tapes, posters, pamphlets, lectures, news stories — there's no scarcity of good educational materials," Dr. Murphy says. "But no matter what you do, there are 20% who will not listen to that education and will continue to misuse or abuse drugs. Drug testing is one way to get their attention so that they will listen."

Thus, unannounced, across-the-board tests on certain teams were initiated. "In 1984-85, OSU tested three men's teams and two women's teams — 250 athletes and support personnel," Dr. Murphy says. "In 1985-86, we tested four men's teams and five women's teams — 414 athletes and support personnel. In 1984-85, 5% of the urine samples showed presence of illegal substances. In 1985-86, that percentage was down to 1.5%."

This year — as of January 1, 1987 — OSU has tested some 680 athletes and analyzed over 3100 urine samples; football players were tested 22 times, says Dr. Murphy. To date, only .2% of team members have had positive samples. "And it's our estimate that without drug testing, our use would be 20%," says Dr. Murphy.

One of the reasons for the declining use, Dr. Murphy feels, is that the university's practice of drug testing keeps those who use drugs from participating in sports. "But the goal of our program is to keep athletes in — not to get them out," he says. National studies, according to Dr. Murphy, show that 80% of all college athletes are totally clean. Of the remaining 20%, 5% will be deterred by education and a firm policy; 5% by drug testing and loss of status on the team; and 5% by the threat of suspension."

The other 5%, he says, "can't get off (of drugs) — and they will use all of the tricks of the trade to avoid detection," including running a rubber tube down inside their clothing in order to produce a clean urine sample that is not their own, says Dr. Murphy. It is that 5% that most concern Dr. Carden, who believes that "they cause 99.9% of the drug problems in this country. The intelligent solution," he says, "is to look for these people."

But society and technology still have not provided the tools to identify and turn around the hard core addict. "Drug testing finds those who experiment with drugs or use them recreationally — not the people with the serious drug problems," says Dr. Carden. The latter group has learned to beat the system, he says — adding bleach or salt to their specimens, drinking large amounts of water to dilute their urine samples, etc.

And impaired physicians and other health care workers are among the best at these kinds of practices. In one extreme case, Dr. Carden relates, a physician who was being tested regularly for drug use made a habit of catheterizing his wife before the tests and filling his own bladder with her urine. After his wife divorced him, he took the dog's urine, according to Dr. Carden.

Yet a great deal of stigma still is associated with substance abuse and addiction, so that families, in order to protect the victim, will help keep it secret for years.

"The family sees the problem at least seven years before it shows up on the job," says Dr. Carden. Family members, rather than work supervisors, "are the main identifiers," he says. "And if they know the victim will be treated with compassion, effectiveness and advocacy, they will turn him or her in" to a quality rehabilitation program by an employer or some other sponsor.

Such is the OSMA's Physician's Effectiveness Program (PEP) which seeks to intervene in cases where physicians are having problems with alcohol and drugs before they harm themselves or their patients. Through PEP, fellow workers, family members and former impaired physicians confront the doctor with his or her problem and direct him or her immediately to a source of help. Following treatment, PEP continues to monitor physicians who have had problems, to make sure they do not fall back into their old habits.

"No other professional organization on the face of the earth can say that 3% of its group is impaired, has been identified and will be followed for life," Dr. Carden says of this program. Yet, compared to urine screenings, "it is an enormous undertaking. There is always more that needs to be done. But it is people, not technology, that will do it."

Unfortunately, says Dr. Carden, even advanced technology,

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"A happy worker is a better worker. Victims of substance abuse are not happy . . ."

including simpler, more reliable methods to test for drugs, will not solve the complex cultural and sociological problem of substance abuse. "Only people and attitudes can do this," he says. A greater clinical understanding of addiction itself, the adoption of new modes for problem solving, a strengthening of the family unit in American society, and greater empathy for the addicted person are some of the more difficult long-term solutions to the complex problem of substance abuse in America, says Dr. Carden.

"A happy worker is a better worker," Dr. Carden agrees. "Victims of substance abuse are not happy — they are slaves to that monkey they carry on their backs." And while the workplace — or the football team — or the military service — may all be good places to start detaching the monkey, it is "compassionate advocacy for the individual and the individual's family" — not the results of a urine test — which will make it happen, Dr. Carden believes. **OSMA**

Susan Porter is the Associate Editor of Ohio Medicine.

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Drug Testing — The Legalities, The Ethics, The Costs

By Karen S. Edwards

Is it legal to test employees for drugs? Is it ethical? What does it cost an employer to learn the "truth" about his or her employees' drug habits? And what are *your* responsibilities, as the physician who may be placed in charge of or asked to participate in a drug-testing program?

Don't expect any easy answers to the above questions. There aren't any.

The issue of drug testing is still too new for there to be any concrete definitions or guidelines on what to do. Mark A. Rothstein, JD, the Director of the Health Law Institute at the University of Houston, perhaps sums it up best when, at a recent open forum on drug testing sponsored by the Ohio State Medical Association, he said the best way to answer any questions on drug testing is with the conditional phrase: "It all depends."

Indeed, the legalities of drug testing seem to depend on a lot of things.

For example, it may depend on the employee's position in the workplace. Is he or she employed in the *public* or *private* sector? It makes a difference.

"Public sector employees have more rights," explains Rothstein.

That's because the Constitution, which protects the rights of every individual citizen in this country, becomes something of a conditional document in the workplace.

The employee who works for a government — be it city, county, state or federal — still has his or her rights (from invasion of privacy and illegal search and seizure) protected by the Constitution. Public sector employees, therefore, can raise more effective *constitutional* objections to drug testing. Of course, whether or not their objections will be considered valid by a court of law is another question, best answered by time and that catch-all phrase, "it all depends."

The employee in the private sector, however, may not be successful in raising *constitutional* objections to drug testing, because, in his or her workplace, there is an implied consent given by the employee at the time of employment that he or she will adhere to any rules or regulations set up by the employer.

"It's the same situation you have when you apply for a driver's license," explains Robert B. Forney, Director of Toxicology at the Medical College of Ohio at Toledo and another speaker at OSMA's drug testing forum. "When you apply for a driver's license, it means you consent to an alcohol test if there is *reasonable* suspicion that you are driving under the influence."

To bring the point even closer to home, Brent Mulgrew, JD, Managing Director and Legal Counsel for the OSMA, focuses attention on the licensing process of the Ohio State Medical Board.

"When applying for or renewing a medical license, or at any time there is reasonable cause, the State Medical Board can require the applicant to submit to certain mental and physical tests — which can include tests for drugs," he says.

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Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

Contraindication: Keflet is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MAOE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflet.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile*. Other causes of colitis should be ruled out.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Precautions: *General*—Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflet occurs, the drug should be discontinued and the patient treated with the usual agents (eg, epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflet may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Keflet should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflet, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—The daily oral administration of cephalexin to rats in doses of 250 or 500 mg/kg prior to and during pregnancy, or to rats and mice during the period of organogenesis only, had no adverse effect on fertility, fetal viability, fetal weight, or litter size. Note that the safety of cephalexin during pregnancy in humans has not been established.

Cephalexin showed no enhanced toxicity in weanling and newborn rats as compared with adult animals. Nevertheless, because the studies in humans cannot rule out the possibility of harm, Keflet should be used during pregnancy only if clearly needed.

Nursing Mothers—The excretion of cephalexin in the milk increased up to 4 hours after a 500-mg dose; the drug reached a maximum level of 4 μg/mL, then decreased gradually, and had disappeared 8 hours after administration. Caution should be exercised when Keflet is administered to a nursing woman.

Adverse Reactions: *Gastrointestinal*—Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely. The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Dyspepsia and abdominal pain have also occurred. As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

Hypersensitivity—Allergic reactions in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson Syndrome, or toxic epidermal necrolysis have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue and headache. Eosinophilia, neutropenia, thrombocytopenia, and slight elevations in SGOT and SGPT have been reported.

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driver or the private sector employee will probably not be successful raising *constitutional* objections to drug testing requirements, that does not mean that he or she must sit silently by — enduring what might be considered an "infringement of rights" — without hope of recourse.

For example, Title VII of the Civil Rights Act prohibits employers from discriminating against employees based on their race, color, sex or place of national origin.

"By requiring a drug test, an employer may unintentionally be discriminating on these grounds, depending on who is being selected for testing," says Rothstein. Of course employees can also file complaints with their unions, or bring the matter to court in a civil liberty suit — but will they hold up? "It all depends."

According to Rothstein, the employer who requires employees in "safety sensitive" jobs to submit to drug testing "probably stands the best chance of having the drug testing program upheld in court."

So does the drug testing program which requires only those employees whom supervisors "reasonably suspect" to be substance abusers to be tested.

However, tests on grounds of "reasonable suspicion" raise a brand new set of questions. For example, is there any proof to go along with "reasonable suspicion?"

Then, there is the question posed by Forney — *should* companies be giving supervisors the ability to choose who to test?

"It's hard enough for trained professionals to know who to test," he comments. Of course, if the employee staggers, mumbles incoherently, or cannot perform his or her task — that's one thing. But the impairment may appear in more subtle ways.

"Airline pilots can show

The OSMA Drug Survey

A majority of OSMA's members responded positively to the concept of drug testing in a recent informal poll conducted by the association. However, the poll revealed that physicians, like the public, generally have mixed feelings on this issue.

The OSMA conducted the survey in February 1987 by including a special questionnaire in its monthly newsletter, the OSMAgram. The purpose of the survey was to help the association determine physicians' attitudes regarding the use of drug testing as a method of identifying drug abusers in the population.

Nearly 1,700 physicians responded to the survey. Of those, 61% agreed or strongly agreed with the statement, "Screening for drug use is an ethically acceptable method of identifying drug users."

However, there was no clear consensus among the respondents as to how and when the testing is to be conducted or as to who should be tested. Forty-eight percent of the respondents agreed or strongly agreed with the statement, "Random drug testing by employers would be an acceptable way to identify employees who abuse drugs." The respondents (77%) also agreed or strongly agreed that employees who hold jobs which impact public health and safety should be required to submit to random drug testing. In addition, 60% agreed or strongly agreed that health care professionals and their employees should be required to submit to random drug testing. However, a little over half of the physicians indicated that drug testing should be done only with just cause. Fifty-seven percent agreed or strongly agreed with the statement, "A person should only be tested for drugs if there is a physical manifestation of drug abuse or a strong suspicion of drug use based on recent performance."

The physicians who responded also expressed some concern over the accuracy and reliability of drug testing. Only 50% agreed or strongly agreed with the statement, "The accuracy and reliability of drug testing has been scientifically proven." In that same vein, the respondents indicated that caution should be used both when administering a drug test and when verifying the results. More than 95% agreed or strongly agreed with the statement, "A physician who orders drug testing should witness (or have an employee witness) the actual taking of the specimen." And more than 80% felt that people who initially test positive should be given the chance for a second test.

Likewise, the respondents were unclear as to what should happen to people who test positive. They were almost equally divided on the issue of whether a verified positive drug test would be acceptable grounds for dismissal of an employee (37%, yes, and 42%, no). However, the majority of respondents indicated that they felt people who test positive should be treated leniently. More than 85% indicated that they agreed or strongly agreed with the statement, "An employee who has a positive verified drug test should be given the chance for counseling instead of being dismissed."

The survey also revealed that physicians are unclear as to the ethical guidelines regarding drug testing — both in regards to who is to be tested and who has access to the results. Nearly 60% indicated that they disagreed or strongly disagreed with the statement, "I would test a patient for drugs in a routine exam, without his or her knowledge, if I suspected drug use." However, nearly the same percentage agreed or strongly agreed with the

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impairment 24 hours after marijuana use," says Forney. "They don't stagger, so their impairment won't be obvious, but they will be unable to accomplish complex tasks, and their reaction time will be slower."

Supervisors will have to receive sophisticated training in order to pick up on such subtle signs, points out Forney.

Then, too, the argument can be raised as to whether or not supervisors, even if properly trained, *should* be given this amount of power.

According to Rothstein, there was a case of a utility worker in the Houston area who claimed that his supervisor hated him. In fact, the supervisor *did* require the worker to submit to *17 urine tests in 18 months* — despite the fact that each test always came back clean. The worker took the case to court, contesting that the number of tests — even though all were negative — would have an ill effect on his record if he were ever to be considered for a promotion. The courts agreed.

The courts are also very concerned with what employers are doing with the results of these tests.

"The court is going to be more favorable toward those drug tests where positive results lead to rehabilitation rather than dismissal," says Rothstein.

That's largely because of a handicap discrimination law which prohibits employers from discriminating against handicapped workers.

"Under the Ohio Civil Rights Act, alcohol and drug impairments are protected handicaps," says Mulgrew.

In those instances where the employee can perform the essential function of his or her job safely and substantially, despite the impairment, the employer may not have the right to fire that employee solely because of the impairment. However, this does not mean the employer may never fire an employee who tests positive for drugs. The Ohio Supreme Court has stated: "Where chemical dependency adversely affects job performance, an employer is clearly within its rights to discharge the employee."

Obviously, a discussion of whether or not drug testing is legal could go on for pages. The points made here are just a few of the issues that have already been raised or challenged in a court of law — and who knows how many more will follow?

Before leaving the matter of legalities behind, however, there is one more question that needs to be pursued, and that is what is *your* legal responsibility as a physician in charge of a company's drug testing program?

"Be aware of the objectives of the testing program you choose to participate in; become involved with development of the testing protocol; and understand the technical aspects of the specific program as well as the issues in the area of drug abuse testing and rehabilitation," advises Mulgrew.

Physicians involved with testing programs should also understand that — as Mulgrew puts it — "a simple, one-step urine screen is an inadequate basis for employer action against an employee. There *must* be a confirming test." Rothstein agrees that unconfirmed tests stand little chance of holding up in court, and Forney goes one step further by suggesting that the type of tests used in the initial screening process should *not* be the same type used in confirming those tests.

Another aspect that needs to be understood by anyone involved with *any* aspect of drug testing is the "chain of custody" concept.

"In the chain of custody, you must be able to prove that it is x's sample in the jar," says Rothman, and proof must be provided at every step along the way — from collection to analysis. Which, of course, raises yet another controversial question — should collections be witnessed?

"If a collection is unwitnessed, a lawyer can challenge whether or not that person's sample has been visually confirmed," says Mulgrew. Only if the collection has been witnessed, *and* the person initials a slip of proof that the urine is his or hers, *and* the sample is sealed and signed by the collectors and the sample is traceable from collection through testing is the question of whose sample is in the jar likely to go unchallenged.

There is no question, however, that witnessed collections are viewed with both embarrassment and distaste by those who are asked to participate in testing.

While Mulgrew agrees that witnessed collections can raise a lot of antagonism among employees, the fact is they are not "illegal" and an employer *can* require witnessed collections and still be within the parameters of the law.

That doesn't mean, however, that cases are not showing up in the courts (they are) — or that, sooner or later, the unwritten policy on witnessed collections may change.

According to Rothstein, public employees whose constitutional rights are protected in the workplace are arguing that there should be privacy both in the process of urination and in analyzing its contents. Again, it will take time before any hard and fast rules come into focus on this issue — if, in fact, they ever do.

If a collection is *not* witnessed, Forney urges physicians to warrant the specimen only from the point of reception — and that "paper trail" which documents custody becomes even more important in unwitnessed collections, he says — especially if the test eventually becomes a matter of litigation.

"If the chain (of custody) breaks at one link, then the whole chain is broken," says Forney, and it may well be you, the physician — with the employer — who will also be sued for negligence if this happens and the employer acts on the results.

Finally, there is the matter of the result. Who has the right to the information, and how much information should be given?

"In Ohio, a doctor must provide medical records to employees on written request, unless the release would amount to serious medical harm to the individual," says Mulgrew.

That, however, does not apply to the applicant who may have been given a drug test as part of a pre-employment physical. Basically, says Mulgrew, he or she has no right to these records.

But neither does the employer necessarily have the right to all the information that's obtained from a drug test on an applicant. Mulgrew asserts that a physician need only release to an employer that information which is applicable to the scope of employment. And while the employer *can* require an employee to have a clean drug evaluation, that doesn't mean the employer is entitled to a printout of specific chemical results . . . or, for that matter, to any information not directly relevant to employment.

How much information the physician *does* choose to give out — to the employer or the employee — often boils down to a matter of ethics.

Rothstein points out that, ethically, a physician should advise an employee if his or her test result proves positive, and allow the employee to explain why this may have occurred. It's quite possible, Rothstein says, that the employee may have forgotten to alert the collector of any legal — meaning prescription or over-the-counter — drugs he or she may be taking.

"The doctor owes it to the employee to find the time to discuss the problem," he adds.

Rothstein openly expresses his *own* views on what he considers to be a proper "code of ethics" for drug testing.

"I would limit the tests to those employees who, if under the influence of a chemical substance, would pose a danger to themselves, to other people or to property. Testing has to be safety-based to be justified . . . and I would limit the tests to as few people as possible," he says.

Rothstein also points out that there should be a reasonable suspicion that the person is a substance abuser before ordering a test — then, he questions whether or not a test, in those cases, is necessary.

"If you know this person can't do the job, that's enough. There's no real reason to order a test."

Should an employer continue to insist, however, Rothstein stresses the importance of accurate drug tests, administered off-site and with valid employee consent.

"And test for everything," he says.

Mulgrew adds the following:

"Tests should be administered in a totally non-discriminatory fashion by qualified professionals, and should be consistently enforced. The employee should be notified of any test in writing, and those who test positive should be given the chance to be rehabilitated."

Establishing ethical guidelines for drug testing, however, does not answer the ultimate ethical question: should employees, athletes, prisoners or anyone, for that matter, be tested for drugs?

Answers to this question do not come so easily.

Looking at the question from a purely economical standpoint, drug testing can be expensive. Forney estimates that costs for a drug testing program can run anywhere from $5,000 to $200,000 depending on the degree of technical sophistication used.

Commonly, costs per confirmation will run $40 — or as high as $80, if the samples are being analyzed for more than common chemical substances.

Many, of course, would argue that this is a small price to pay to assure the safety of a planeload of passengers or those living near a nuclear power plant.

But Forney feels differently.

"No way can a positive result from a drug test prove drug impairment," he says.

He points out that there is no way to tell, through a test, whether the measurable quantity of opiate in a urine sample is the result of a person who regularly smokes opium or one who just so happened to eat a poppy-seed bagel for lunch. Neither is a test able to determine the difference between the individual who smokes marijuana and the person who may have inadvertently inhaled the smoke. As sophisticated as laboratory testing is, it still could be better.

"Drug testing does not provide any information on the abuse of drugs," says Mulgrew. "Drug testing identifies exposure — not impairment. And impairment is the real issue for employer concern."

Rothstein agrees that drug testing offers no "quick fix" to the problem of drugs in the workplace.

"We need drug education and rehabilitation programs to take care of the problem," he suggests.

But Forney is not so sure.

"Educational programs which teach employees not to use drugs generally don't work," he claims. "Millions have been spent on cigarette warnings and education, but people still smoke. The money being spent is proving ineffective."

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What the Spirit of Caring Means to Me ...



"To me, the spirit of caring is a reaffirmation of my commitment to my patients. In these times, when we are preoccupied by PPOs, IPAs, HMOs and discounted fee-for-service, physicians may unconsciously forget that we are the primary care givers. We must all step aside from the whistles and red tape, and remember that the primary role of the physicians *is* to take care of patients."

— K. William Kitzmiller, MD
OSMA Delegate, Hamilton County



"Radiologists care for beams of ionizing radiation, waves of magnetically resonating energy, bursts of ultrasonic frequencies, masses of nuclear disintegrations, quantums of accelerated particles and images of computerized pixels — or do they? Of course not! Those physical elements are only the tools for giving loving care to patients. Whether the patient is about to be moved into the somewhat awesome core of a huge magnet for study of the body's protons, or about to be placed all alone under a linear accelerator, or about to have an arterial incision for the insertion of an angiographic device, the most important consideration is "The Spirit of Caring" for the patient.

— Theodore J. Castele, MD
OSMA Delegate, Cuyahoga County

"We physicians have an additional responsibility with regard to caring. Doctors have the opportunity to care **FOR** people — their patients — as well as an obligation to care **ABOUT** people — their friends. It is this 'caring about' spirit which adds a professional dimension to an otherwise technical construct. The 'caring about' spirit adds the artistry to the science of medicine. The 'caring about' spirit adds weight to the doctor's otherwise heavy load, but adds credibility to the doctor's decision and trust to the doctor-patient relationship. The spirit of caring is the spirit of the practice of medicine."

— A. Robert Davies, MD
OSMA Delegate, Franklin County





"The classical painting of the American physician sitting and comforting the sick child at the bedside portrays the traditional compassionate role of the patient advocate. In those days the family doctor provided his sincere spirit of caring. Though his knowledge and skills were limited, he professed the high standards of the medical profession without economic or political harassment.

"The environment in which medicine is practiced today has changed and become very unstable. Alternate delivery systems proliferate, competition is intensifying, litigation is abominable and pressures to control fees and costs are increasing.

"The government, industry and third-party entrepreneurs have become adversarial agents to medical practice by expanding legislative reimbursement controls and limiting access to medical care.

"Organized medicine must take every opportunity to fight these pressures in order to ensure patients' access to high-quality medical care."

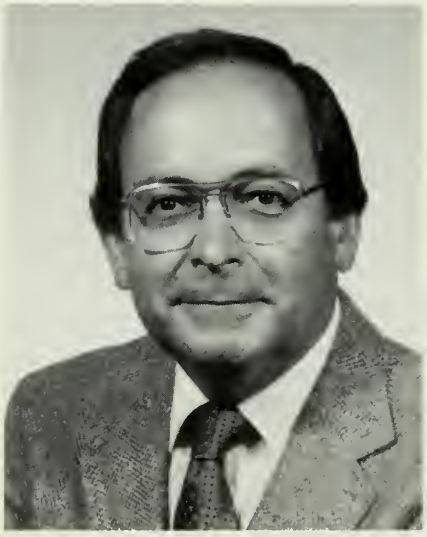
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"Caring is sharing. We value man's trust in giving the fate of his life to his fellowman. In return, we offer our availability, reliability and accountability in professional skill and knowledge.

"But we have to deliver this in a compassionate manner."

— H.S. Wang, MD
OSMA Delegate, Mahoning County



"These are difficult times for American medicine and the patients we are privileged to serve. Emphasis is on cost containment and not quality of care.

"We must rededicate ourselves to professionalism and quality of care and keep the spirit of caring alive in our daily practice — 'Care with Caring.' "

— **B. Leslie Huffman, Jr., MD**
OSMA Delegate, Lucas County



"The spirit of caring — the reason we chose to be physicians . . . that special altruism with which we entered medical school . . . to care . . . to heal . . . to comfort. How fragile that spirit! How difficult the struggle to prevent its withering in the face of mindless bureaucracy, insoluble social ills and monetary preoccupations."

— **Claire V. Wolfe, MD**
OSMA Delegate, Franklin County



"The spirit of caring describes the fundamental philosophy of the medical profession. By considering the patient's welfare first, the physician not only helps the patient, but ultimately promotes his or her own success as well. The medical profession is unique in making this claim."

— **Douglas S. Hess, MD**
OSMA Delegate, Wood County



"Caring reflects the compassion of the old country doctor, always being the patient advocate even when 'nothing can be done,' and taking time to allay patient fears. It also means caring about the image of our profession and being involved in organized medicine to protect not only the physician but our patients."

— **D.A. Baumgartner, Jr., MD**
OSMA Candidate for President-Elect



"The giving of a feeling of safety, well-being, confidence and reassurance in an enthusiastic, competent and professional manner — without regard for personal gain — is what the spirit of caring means to me.

"If, as individuals and as OSMA, we represent and convey this concern for our patients and our profession, our identity as caring physicians will be enhanced."

— **George E. Ewing, MD**
OSMA Delegate, Stark County



"The spirit of caring means not saying 'let the other guy do it,' but doing it myself. I feel I have an obligation to pay my dues to my profession, which I do by involving myself in activities promoting the interests of medicine and of my patients."

— **William C. Miller, MD**
OSMA Delegate, Hamilton County



"The doctor-patient relationship — that special interaction that makes our profession unique; a relationship born of need but nurtured by trust and in its fullness an empathy of one being for another that is a depth of sharing, which is the quintessence of one human being caring about and caring for another."

—Lee J. Vesper, MD
OSMA Delegate, Hamilton County



"The spirit of caring brings to my mind, and perhaps is best illustrated by the well-known painting of the physician at the bedside of an ill child studying the signs as well as reassuring the young patient.

"I interpret his studied expression as one of deep concern, empathy of a high degree, and at the same time, application of all of his known technical skills to be certain his diagnosis is correct and that the available and proper treatment is being applied.

"To me, this picture embodies the 'spirit of caring.' "

—Paul S. Metzger, MD
OSMA Delegate, Franklin County



"Caring is an essential tool for all physicians. It is a God-given gift — this empathy, this love for his fellowman. The special bond that is developed between the physician and his patients is nurtured by his 'Spirit of Caring' which has been entrusted in him by his Creator."

—Richard R. Villarreal, MD
OSMA Delegate, Scioto County



"The spirit of caring ignites the decision, fuels the enthusiasm for years of study, and replenishes the wellspring of empathy during a lifetime of practicing (but never perfecting) the healing arts."

— Jayne W. Dye, MD
OSMA Delegate, Fairfield County



"Caring is to try to identify yourself with other people's feelings. I hope that I can gain the trust and confidence of my patients, to form a relationship and first to be a human being and then a physician. In the eyes of my patients, I wish to perform in a way that they are confident that the care I will give them is the best of which I am capable."

— Carlos O. Andarsio, MD
OSMA Delegate, Clark County

"These are trying times of governmental and other third party insurers with constant intrusion and regulations. It is of vital importance that physicians rise to the challenge and place every emphasis on maintaining a close patient relationship and rapport, showing every concern and understanding to provide the best medical care possible."

— Thomas F. Moriarty, MD
OSMA Delegate, Henry County





"The spirit of caring means being aware of the whole patient and the sphere of influence around him or her. The myths, fears, self-blame and prejudices must be honestly answered to fully care for the patient. The patient and family can cope and comply much better with such complete caring."

— Lance A. Talmage, MD
OSMA Delegate, Lucas County



"When you get out of a warm bed on a cold winter's night to see a sick child, that's caring . . . The smile on the mother's face when you arrive at her front door, that's caring . . . When you see the smile on the child's feverish face after you greet him . . . that's caring."

— Thomas C. Dozier, DO
OSMA Delegate, Auglaize County



"A prime requisite for caring is listening. It is the most difficult thing to do in the course of a busy day practicing medicine. Yet listening gives us insights into our patients' needs, concerns, and expectations. It sharpens our understandings and focuses our efforts to best serve our patients."

—Ronald B. Berggren, MD
OSMA Delegate, Franklin County



"There's no substitute for the Golden Rule: 'Do unto others as you would have them do unto you.' No matter the person's station, give the best you have. Make the patient feel important by listening. Stay current. Touch and maintain eye contact. Be there when needed, radiate confidence and always leave hope."

— John W. Ray, MD
OSMA Delegate, Muskingum County



"Today's physicians are being challenged to separate the 'utilitarian' business aspect of medicine from the professional aspect. We must strengthen our commitment to the ethical and humanistic approach to the healing arts. The 'spirit of caring' is expressed in our fulfillment from this most exciting profession and the gratification we receive from helping those whom we touch."

— Jeffrey Siminovitch, MD
President,
Lake Co. Medical Society



"Caring is doing the extra things that make people feel worthwhile, a postoperative phone call at home to a lonely senior citizen, a finger puppet used in an eye examination for a frightened toddler and taking the time to really listen, not just hear. A little caring goes a long way!"

— Ronald C. Agresta, MD
OSMA Delegate, Jefferson County



"The spirit of caring is the very foundation of our system of health care in this country. It is this spirit that challenges us daily to put the quality of care we deliver to our patients first. This commitment to quality makes the American health care system the best in the world."

— **Herman I. Abromowitz, MD**
OSMA Delegate, Montgomery County

"An investment in knowledge pays the best interest."



Your Government has published thousands of books to serve America. And now the Government Printing Office has put together a catalog of the Government's "Bestsellers"—almost a thousand books in all. Books like *The Space Shuttle at Work*, *Starting a Business*, *U.S. Postage Stamps*, and *National Parks Guide and Map*. I daresay there's even information on one of my favorite subjects—printing.

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Clinical Genetics Handbook

Medical Economics Books, Oradell, New Jersey 07649
Editors — Ruth Y. Berini, Executive Editor
Eva Kahn, Editor
354 pages, Paperback, 1987

Over the past several years, remarkable progress has been made in genetic diagnosis and therapy. Many practicing physicians have had minimal education in genetics and even recent medical graduates need a ready source of basic information in order to properly evaluate and advise their patients. Such a source is *Clinical Genetics Handbook,* a "manual" briefly summarizing important facts on a wide variety of genetic disorders. It is purportedly written for the primary care physician, but it will also be of value for subspecialists because it includes information on such topics as genetic disorders of vision, hearing, skin, bone and psychiatric disorders.

The book is divided into three main sections. The first, entitled "Applied Genetics," succinctly reviews genetic mechanisms and the principles and methods of genetic counseling. It is an excellent reference for the physician wishing to quickly review this information. The second section, entitled "Disorders in Clinical Genetics," logically groups genetic disorders into categories such as mental retardation, chromosome disorders, disorders of various organ systems, psychiatric disorders, neoplasia and pharmacogenetics. The third section, perhaps the weakest of all, is entitled "Concerns in Family Planning," and addresses the issues of reproductive failure and consanguinity. In one chapter it mixes such diverse topics as sex chromosome abnormalities and abortion and stillbirth. Most sections are followed by a short list of recent references, for those wishing more indepth information.

Each chapter is written in the same format, usually beginning with an introduction to the disorder(s), followed by etiology and pathogenesis, genetic characteristics and mode of inheritance, clinical notes, procedures for diagnostic confirmation and considerations in management.

I am uncertain about the qualifications of the executive editor and editor. They acknowledge Arthur Robinson, MD, Director of the Cytogenetics Laboratory of National Jewish Hospital in Denver as Medical Advisor. The chapters themselves are apparently written mostly by a number of non-physician genetic counselors. Each chapter has apparently been reviewed by a physician knowledgeable in the field, although it is difficult to understand the fact that there has been no input either as an author or reviewer by an obstetrician/gynecologist, even for the chapter on prenatal diagnosis. Individual chapters are not identified as to author and reviewer.

The material is mostly well organized, concise, and easy to understand. Virtually all common genetic conditions are presented and the book serves as a handy reference for the physician needing immediate information to advise a patient. Most chapters have charts or tables showing characteristics of various disorders of that particular organ system and their method of inheritance, further simplifying access to the information. With a few exceptions, such as a brief, entirely narrative description of the metabolic role of G6PD, the material is easy to understand. Because of its brevity and simplicity, the book might be also ideal reading for patients who wish to obtain additional information about conditions affecting themselves or their families. I do, however, have some concerns about patients misunderstanding certain parts, such as statements which imply that viral studies on amniotic fluid may be clinically useful in predicting fetal disease and that in utero therapy of fetal hydrocephalus is a valuable procedure. To my knowledge, neither has been proven and unreasonable expectations may occur.

There are a few minor points which I think might strengthen the book. A chapter on epilepsy and its treatment lists various teratogenic effects of the anticonvulsant agents. In the listing for Primidone it indicates that this is a Category D drug and "risks may exceed benefits." However, it does not specifically indicate what those risks are as it does with the other drugs. Specific information would be more helpful in the management of a particular exposed patient. Also, the chapter on Tay-Sachs disease should emphasize to the primary care physician the advantage of screening for carrier status prior to pregnancy. It is mentioned that, if necessary, white cell levels rather than serum levels of hexosaminidase A can be obtained during pregnancy, but does not really reflect the fact that pre-pregnancy screening is a much more practical approach and allows the patient to enter the

There are many positive things about the book, including the excellent charts, the fact that the book is current and comprehensive, and is exceptionally well indexed.

pregnancy fully informed. Likewise, there is a good discussion of the effect of PKU on pregnancy, but little is mentioned about screening for maternal PKU either before or during pregnancy. Also for the physician delivering prenatal care, a flow sheet detailing the management of the patient with an elevated or low serum alpha fetoprotein would be most helpful to those not frequently faced with the problem. Finally, the techniques of recombinant DNA are too new and too complex to be simply mentioned in passing in short paragraphs. Unfortunately, all physicians, except those who have made an effort to understand the subject, will probably simply pass over such statements and will not understand clinical applications. Although it is a difficult subject, the editors, in choosing not to include a chapter which would attempt to concisely and simply explain recombinant DNA techniques, missed a valuable chance to improve understanding of a subject which will become increasingly important in genetic diagnosis and therapy.

There are many positive things about the book, including the excellent charts, the fact that the book is current and comprehensive, and is exceptionally well indexed. There is an excellent narrative description of the embryology of oral clefts. The very important subject of familial cancers receives the three chapters it deserves.

As a practicing obstetrician/gynecologist who frequently is called upon for genetic counseling, I plan to keep my copy of *Clinical Genetics Handbook* within easy reach. In retrospect, it certainly would have been very helpful and time saving for many patients I have seen in the past, and I would anticipate it to continue to be so in the future. I think it is a worthwhile addition to the bookshelf of any physician caring for the pregnant patient and should be required reading for house staff in obstetrics/gynecology and Family Medicine.

In addition, because genetic counseling is frequently an issue for the non-pregnant, I think it would be useful for virtually any physician advising patients about potential genetic disorders. Such a book has been much needed and this effort has mostly hit the mark. Hopefully, it will be updated as needed by the progress of the science, and subsequent editions may make some of the minor changes which would make the book even more useful. **OSMA**

— **Alvin Langer, MD**
Academic Director
Department of OB-GYN
NEOUCOM
Canton

Faculty Position
University Physician/Director of Health Services

The University. The University of Akron is the third largest state-assisted university in Ohio. Located on a 150-acre campus, the University serves about 26,000 day and evening students—2,160 of whom reside on campus. It offers 233 associate's, bachelor's and master's degree programs and 14 doctoral degree programs.

The Position. The University physician/director of Health Services will report to the associate provost and dean of student services and is responsible for administration of the health service, including program planning, budgeting, and supervision of three part-time physicians and 10 R.N.s. Two of the part-time physicians are orthopedists with the athletic department. The director serves as physician to all University students and provides service to employees and visitors in cases of emergency. The director works closely with local hospitals, physicians, dentists, health departments and other health-related agencies; and promulgates health-related forms and guidelines.

Qualifications: Priority will be given to applicants with the following qualifications: Permanent and full, unrestricted license to practice medicine in Ohio and a member in good standing of the Ohio State Medical Association, and associate member or member in good standing of the Summit County Medical Society. Preference will be given to BE/BC family practicioners or internists for a primary care-type practice.

Salary: Commensurate with qualifications and experience.

The position will be available September 1, 1987.

Applications: The deadline for applications and nominations is June 5, 1987. Applications should include a letter expressing interest, a complete resume, supporting materials as appropriate, and names and addresses of three references. Nominations and applications may be sent in confidence to: Dr. Robert A. Dubick; Office of Student Services; The University of Akron; Akron, OH 44325.

The University of Akron

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Total Return Investing

An Asset Allocation Approach to Investing Physicians' Retirement Plans

By James L. Budros, CFP, ChFC

AXIOM: There is no *best investment for all time.*
COROLLARY: For any period of time there is *a best investment.*

This axiom and its corollary suggest that by expert allocation of investments, an investor can achieve a superior total rate of return by not adopting a buy and hold approach. Total return investing is not market timing. Market timing has been traditionally defined as buying stocks as represented by the Standard & Poors 500 stock index, during periods of up stock market cycles and by selling the Standard & Poors 500 stock index during down market cycles and investing in money market investments such as treasury bills.

Asset allocation or total return investing is a flexible portfolio management strategy and involves the active shifting of funds between three types of assets — cash, bonds and stocks — over the course of economic cycles. Proper anticipation of the change of the economic cycle is an important ingredient in successful total return investing, as change is ever present. Change is difficult to cope with as it forces investors from what is familiar to that which is unfamiliar and uncertain. A successful investment program requires that a portfolio be properly invested before an anticipated change occurs, such that full financial advantage may be taken of the perceived change. Most mutual funds and the technique of investment timing only utilize one asset at a time. For example, money market funds diversify among various cash instruments, bond investments diversify in bonds, and stock funds in stocks. "Balanced" funds diversify to a balanced mix of these investments, but they do not asset allocate because there is no active shifting between assets.

Asset allocation, or total return investing, provides an investor with a greater hypothetical total return than either a "buy and hold" or "market timing" style of management.

Hypothetical gains using a buy and hold strategy in either stocks, bonds or cash over the past five years, from 1981 to 1986, using the S & P 500, long-term government bonds and 90 day treasury bills, show a maximum gain of approximately 165% or an average annual return of 10.5%. Perfect market timing, moving investments between bonds and cash or stocks and cash to maximize return, produces a maximum gain of 326% or an average annual return of 27% over this same five year period. This is an approximate doubling of the total rate of return over the buy and hold strategy.

Hypothetical perfect asset allocation — correctly shifting assets between stocks and bonds and cash — produces a return of almost 500% or an average annual return of 37%.

The lesson of these numbers is not that asset allocation/total return investing is always correct, but that an investor has an

Total return/asset allocation investing constantly monitors the economy, interest rates, inflation and GNP.

opportunity for a superior rate of return if one adopts such a strategy.

The investment objective and policy of a very successful total return/asset allocation mutual fund is as follows: "The funds investment objective is to realize a combination of income and capital appreciation which will result in the *highest total return* while assuming *reasonable risks.* The term 'reasonable risks' refers to the advisor's judgment and investment in certain securities would not present a greater than normal risk of loss in light of current and reasonably anticipated future general market and economic conditions, trends in yields and interest rates, and fiscal and monetary policies."

In seeking to obtain the funds objective, the fund intends to pursue a *flexible investment policy* and invest primarily in common stocks, both growth and income oriented, corporate bonds and debentures, short-term money market instruments, such as United States treasury bills, bank certificates of deposit, and commercial paper . . . The fund seeks to generate *real (inflation plus) growth* during favorable investment periods and will emphasize income and *capital preservation during uncertain investment periods* . . .

At times the fund may be 100% invested in common stocks and other equity type securities. On the other hand, when the fund believes that in the light of current economic and market conditions, its investment objectives may be more readily attainable by investment and fixed income securities, it may invest up to 100% of its assets in corporate bonds and debentures and in short-term money market instruments . . .

The fund's investment policy is very flexible. The fund may invest in all types of common stocks and other equity investments, without regard to any objective investment criteria such as size, exchange listing or seasoning. The fund may invest in both exchange listed and over the counter securities, in small or large companies, and in well established or unseasoned companies. Also the funds investment in corporate bonds and debentures and short-term money market instruments is not restricted by ratings or other objective investment criteria . . . The selection of the investments will depend solely on the advisor's judgment that the investment selected will further the attainment of the fund's investment objective . . .

Through its *active management* of the portfolio and flexible approach to investing, the advisor seeks to avoid or reduce the degree of negative change in the fund's net asset value per share and seeks to *provide positive returns even in declining markets."*

Total return/asset allocation investing constantly monitors the economy, interest rates, inflation and GNP. Are the indexes high or low? Moving up or down? Moving fast or slow? If the analysis of the investment advisor shows a change in the economic environment, the advisor adjusts the asset allocation mix accordingly.

Most total return/asset allocation funds have low market volatility. The relationship of a fund's response to a change in the S & P 500 is measured by a mathematical factor called Beta. The asset allocation funds typically have low "betas" below one, representing that they can be expected to increase during up market cycles less than the S & P 500 and can be expected to decline less than the S & P 500 in down market cycles. This *"defensive"* investing approach produces an overall total rate of return that is significantly better than the S & P 500 index. This is so because the debilitating effects of down market cycles are lessened or altogether avoided. The significance of avoiding down markets is dramatically emphasized by the following example. If an investment worth ten declines to five, the investor is said to have lost 50% of the investment value. At five, the investment must now produce a return of 100% to return to its break-even point of ten. Therefore, it can be concluded that it is twice as hard to recoup a loss than to have lost it in the first place and that the attendant risks accompany the attempt to return to break-even. Therefore, the avoidance of accepting losses during down market cycles as is the case in the "buy and hold strategy" is to be actively pursued. And it is the thesis of total return/asset allocation investing that this can be achieved.

An investment company president has said, "Asset allocation is the most important, yet least studied factor in the investment equation . . . good asset allocation can result in the whole being more than the sum of


130
120
110
100
90
80
70
60
50
40
30
20
10
0
In mild to moderate hypertension
THE FIRST ONCE DAILY
CALCIUM CHANNEL BLOCKER...

NEW
ONCE DAILY



ISOPTIN SR*

(verapamil HCl/Knoll)

240 mg scored, sustained-release tablets



JAMES B.
38, black male, heavy smoker. Prescribed a diuretic by another physician last year for hypertension.

YOUR CONCERNS
Presents with "smoker's cough." Workup reveals a BP of 150/107.

A LOGICAL CHOICE FOR CONTROL OF HIS BP
ISOPTIN* (verapamil HCl/Knoll) because...
— Black hypertensives often have low plasma renin activity and generally do not respond favorably to beta blockers.
— Beta blockers may increase the likelihood of bronchospasm.

ALICE W.
65, diabetic, overweight. Her BP has elevated to 190/98.

YOUR CONCERNS
She's on daily insulin.

A LOGICAL CHOICE FOR CONTROL OF HER BP
ISOPTIN* (verapamil HCl/Knoll) because...
— Unlike most beta blockers and diuretics, ISOPTIN has no adverse effects on serum glucose levels.
— Unlike most beta blockers, ISOPTIN does not mask the symptoms of hypoglycemia.





THOMAS G.
70, asthmatic. In the past, BP adequately controlled with 25 mg hydrochlorothiazide daily.

YOUR CONCERNS
Today patient presents with symptoms of gout. Workup reveals high uric acid level, low serum potassium, and BP elevated to 180/98.

A LOGICAL CHOICE FOR CONTROL OF HIS BP
ISOPTIN* (verapamil HCl/Knoll) because...
— Unlike diuretics, ISOPTIN will not decrease serum potassium levels or elevate uric acid levels.
— Unlike beta blockers, ISOPTIN can be used safely in asthma and COPD patients.

JOHN K.
42, Annual physical uncovered diastolic BP of 102... confirmed on three successive office visits. Unresponsive to nonpharmacologic intervention.

YOUR CONCERNS
Salesman, spends many hours of his working day in car... total cholesterol level 300, HDL 35.

A LOGICAL CHOICE FOR CONTROL OF HIS BP
ISOPTIN* (verapamil HCl/Knoll) because...
— Unlike diuretics, ISOPTIN does not cause urinary urgency.
— Unlike either beta blockers or diuretics, ISOPTIN will not adversely affect his already seriously compromised lipid profile.
— Unlike with propranolol, fatigue and impotence are rarely reported.



Antihypertensive therapy you and your patients can live with

*A product of Knoll research.

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Please see adjacent page for brief summary.

In mild to moderate hypertension

Brief Summary

THE FIRST ONCE DAILY CALCIUM CHANNEL BLOCKER

ISOPTIN® SR (verapamil HCl/Knoll) 240 mg scored, sustained-release tablets

CONTRAINDICATIONS: 1) Severe left ventricular dysfunction (see WARNINGS), 2) Hypotension (less than 90 mmHg systolic pressure) or cardiogenic shock, 3) Sick sinus syndrome or 2nd or 3rd degree AV block (except in patients with a functioning artificial ventricular pacemaker).

WARNINGS: Heart Failure: ISOPTIN should be avoided in patients with severe left ventricular dysfunction (see DRUG INTERACTIONS). Patients with milder ventricular dysfunction should, if possible, be controlled before verapamil treatment. Hypotension: ISOPTIN (verapamil HCl) may produce occasional symptomatic hypotension. Elevated Liver Enzymes: Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Periodic monitoring of liver function in patients receiving verapamil is therefore prudent. Accessory Bypass Tract (Wolff-Parkinson-White): Patients with paroxysmal and/or chronic atrial flutter or atrial fibrillation and a coexisting accessory AV pathway have developed increased antegrade conduction across the accessory pathway producing a very rapid ventricular response or ventricular fibrillation after receiving intravenous verapamil. While this has not been reported with oral verapamil, it should be considered a potential risk. Treatment is usually D.C.-cardioversion. Atrioventricular Block: The effect of verapamil on AV conduction and the SA node may cause asymptomatic 1st degree AV block and transient bradycardia. Higher degrees of AV block, while infrequent (0.8%), may require a reduction in dosage or, in rare instances, discontinuation of verapamil HCl. Patients with Hypertrophic Cardiomyopathy (IHSS): Although verapamil has been used in the therapy of patients with IHSS, severe cardiovascular decompensation and death have been noted in this patient population.

PRECAUTIONS: Impaired Hepatic or Renal Function: Verapamil is highly metabolized by the liver with about 70% of an administered dose excreted in the urine. In patients with impaired hepatic or renal function verapamil should be administered cautiously and the patients monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacological effects (see OVERDOSAGE).

Drug Interactions: Beta Blockers: Concomitant use of ISOPTIN and oral beta-adrenergic blocking agents may be beneficial in certain patients with chronic stable angina or hypertension, but available information is not sufficient to predict with confidence the effects of concurrent treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities. Digitalis: Clinical use of verapamil in digitalized patients has shown the combination to be well tolerated if digoxin doses are properly adjusted. However, chronic verapamil treatment increases serum digoxin levels by 50 to 75% during the first week of therapy and this can result in digitalis toxicity. Upon discontinuation of ISOPTIN (verapamil HCl), the patient should be reassessed to avoid underdigitalization. Antihypertensive Agents: Verapamil administered concomitantly with oral antihypertensive agents (e.g., vasodilators, angiotensin-converting enzyme inhibitors, diuretics, beta blockers, prazosin) will usually have an additive effect on lowering blood pressure. Patients receiving these combinations should be appropriately monitored. Disopyramide: Disopyramide should not be administered within 48 hours before or 24 hours after verapamil administration. Quinidine: In patients with hypertrophic cardiomyopathy (IHSS), concomitant use of verapamil and quinidine resulted in significant hypotension. There has been a report of increased quinidine levels during verapamil therapy. Nitrates: The pharmacologic profile of verapamil and nitrates as well as clinical experience suggest beneficial interactions. Cimetidine: Two clinical trials have shown a lack of significant verapamil interaction with cimetidine. A third study showed cimetidine reduced verapamil clearance and increased elimination to 1/2. Anesthetic Agents: Verapamil may potentiate the activity of neuromuscular blocking agents and inhalation anesthetics. Carbamazepine: Verapamil may increase carbamazepine concentrations during combined therapy. Rifampin: Therapy with rifampin may markedly reduce oral verapamil bioavailability. Lithium: Verapamil may lower lithium levels in patient on chronic oral lithium therapy. Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no evidence of a carcinogenic potential of verapamil administered to rats for two years. Verapamil was not mutagenic in the Ames test. Studies in female rats did not show impaired fertility. Effects on male fertility have not been determined. Pregnancy (Category C): There are no adequate and well-controlled studies in pregnant women. ISOPTIN crosses the placental barrier and can be detected in umbilical vein blood at delivery. This drug should be used during pregnancy, labor, and delivery, only if clearly needed. Nursing Mothers: ISOPTIN is excreted in human milk, therefore, nursing should be discontinued while verapamil is administered. Pediatric Use: Safety and efficacy of ISOPTIN in children below the age of 18 years have not been established.

ADVERSE REACTIONS: Constipation 8.4%, dizziness 3.5%, nausea 2.7%, hypotension 2.5%, edema 2.1%, headache 1.9%, CHF/pulmonary edema 1.8%, fatigue 1.7%, bradycardia 1.4%, 3° AV block 0.8%, flushing 0.1%, elevated liver enzymes (see WARNINGS). The following reactions, reported in less than 1.0% of patients, occurred under conditions (open trials, marketing experience) where a causal relationship is uncertain; they are mentioned to alert the physician to a possible relationship: angina pectoris, arthralgia and rash, AV block, blurred vision, cerebrovascular accident, chest pain, claudication, confusion, diarrhea, dry mouth, dyspnea, ecchymosis or bruising, equilibrium disorders, exanthema, gastrointestinal distress, gingival hyperplasia, gynecomastia, hair loss, hyperkeratosis, impotence, increased urination, insomnia, macules, muscle cramps, myocardial infarction, palpitations, paresthesia, psychotic symptoms, purpura (vasculitis), shakiness, somnolence, spotty menstruation, sweating, syncope, urticaria. Treatment of Acute Cardiovascular Adverse Reactions: Whenever severe hypotension or complete AV block occur following oral administration of verapamil, the appropriate emergency measures should be applied immediately, e.g., intravenously administered isoproterenol HCl, levarterenol bitartrate, atropine (all in the usual doses), or calcium gluconate (10% solution). If further support is necessary, inotropic agents (dopamine or dobutamine) may be administered. Actual treatment and dosage should depend on the severity and the clinical situation and the judgment and experience of the treating physician.

OVEROOSAGE: Treatment of overdosage should be supportive. Beta-adrenergic stimulation or parenteral administration of calcium solutions may increase calcium ion flux across the slow channel, and have been used effectively in treatment of deliberate overdosage with verapamil. Clinically significant hypotensive reactions or fixed high degree AV block should be treated with vasopressor agents or cardiac pacing, respectively. Asystole should be handled by the usual measures including cardiopulmonary resuscitation.

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Total Return Investing

continued

the parts . . . I believe asset allocation is going to get much more attention and that the investment stars of the future will be the funds who make the correct asset allocations calls."

As one popular brokerage advertisement suggests, "If you are not a professional investor, you are an amateur by definition." Most physicians do not devote sufficient attention to retirement funds investing and therefore must rely on the advice of others. Total return/asset allocation investing through mutual funds that seek this investment strategy can significantly enhance retirement security. **OSMA**

James L. Budros is a vice president with SMB FINANCIAL PLANNING, a member of the PICO Financial Services Group which provides specialized financial planning services to physicians and other professional individuals and corporations.

Health-care costs: Going up in smoke?

The price of cigarettes is going up — at least with regard to the amount spent each year on tobacco-related illnesses.

The medical costs of smoking now accounts for 10 percent of all health-care costs spent in this country, some $40 billion a year. According to Blake Cady, MD, a cancer surgeon at New England Deaconess Hospital in Boston, that figure exceeds the total price of all cigarettes sold in this country.

IMAGINE A MACHINE THAT CAN DO THIS TO RENAL CALCULI

We're proud to announce the introduction of Extracorporeal Shock Wave Lithotripsy as a new feature of our kidney stone treatment program. This new device makes it possible to pulverize and eliminate kidney stones without invasive surgery. Now you have the opportunity to participate in this state-of-the-art procedure at CAMC's High Tech Center here in Charleston, West Virginia.

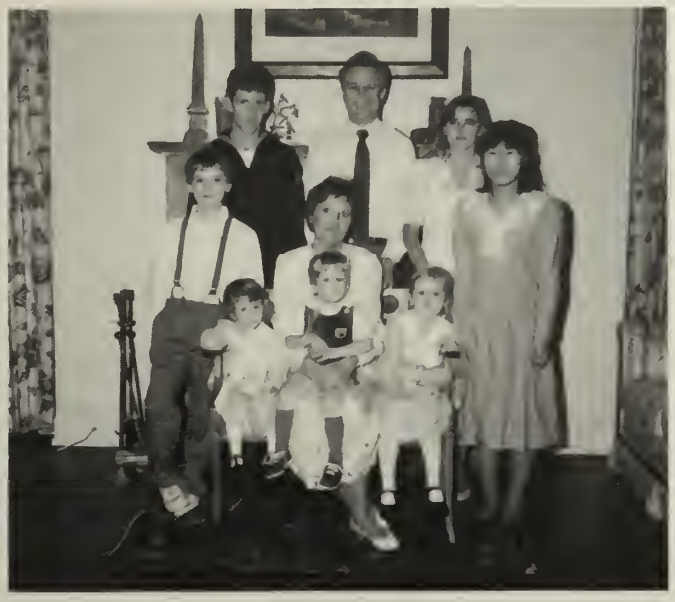
The Lithotripter uses shock waves to bombard kidney stones into sand-like particles inside the body. The residue is then easily passed. Although the theory behind Lithotripsy is simple, the process is precise. The stone is pinpointed inside the body with fluoroscopy and shock wave firing is synchronized with the patient's heartbeat by electrocardiogram. Usually, the entire process takes about an hour.

As you can imagine, Lithotripsy offers many benefits to kidney stone patients. The process is less painful, entails fewer side effects, and recuperation is quicker than with conventional surgery. It's even less expensive than surgery.

We're encouraging all area urologists to apply for privileges in Extracorporeal Shock Wave Lithotripsy. We invite you to visit CAMC and see the lithotripter in action. Come and learn about this revolutionary therapy. We will happily provide you with a brochure for your use as well as brochures for your patients.

For your brochures or other information about Lithotripsy and our kidney stone treatment program, call CAMC: in West Virginia at 1-800-654-0159; from out of state, call 304-340-7315.

CAMC
Charleston Area Medical Center
We Care For West Virginia



Standing l. to r.: Adam, 11; Tim, 19; Dr. Janiak; Tracy, 18; Rebecca, 12.
Sitting l. to r.: Lauren, 2; Mrs. Janiak; Matthew, 3; Sarah, 3.

The Spirit of Caring ... Foster Parenting

By Deborah Athy

The most commonly asked question about foster parenting is: How can you give these children up after you've grown attached to them?

According to Michele and Bruce Janiak, MD, of Toledo, who have been foster parents for about seven years, this concern is "hokum," because both the parents and the children usually gain more than they lose in the foster parenting experience.

For example, the Janiaks relate the time they brought a set of 8-month-old twins to meet their new adoptive parents for the first time. The Janiaks had been foster parenting the twins until the adoption was settled. "I don't know who was crying the most," Mrs. Janiak recalls. "The new father couldn't speak. They had been waiting for years for one baby, and now they were getting two . . ."

The feeling of presenting these babies to their new parents more than makes up for the sadness in letting the children go, the Janiaks explain. "It's such a neat feeling to be a part of this. Chances are, you won't hear from them again . . . but it's such a kick when you see their (the parents') faces: they just light up."

Still, the Janiaks admit it is a bittersweet exchange. They do get attached to their foster children and are sad to see them go. But they know from the start that the arrangement is only temporary, and "every time we get to bring a child to their new parents it's worth it," they say.

Since 1980, some 30 children of varying sizes and ages have been welcomed into the Janiak homestead. Most children stay two to three months, although some have stayed as long as eight months or as little as one week (usually emergency placements in these cases, they add).

Their medical backgrounds have continued to play a role in their foster parenting experiences. For example, they are quick to pick up on medical situations — whether it's an illness or a developmental problem.

At present, the Janiak clan includes three biological children: Tim, 19 (currently in the Navy); Tracy, 18 (attending Bowling Green State University); and Adam, 11. Their family also includes four adopted children: Rebecca, 12 (who arrived from Korea last March); Matthew, 3; Sarah, 3; and Lauren, 2. In addition, two foster children — a 3-year-old and an infant — recently left. (By the way, the Janiaks have a nanny to assist with the family-rearing.)

While Tim and Tracy live away from home, how does, say, Adam, feel about sharing the limelight with these other children? Sometimes he probably thinks "life would be easier if we didn't have these children or if he were an only child," Mrs. Janiak says. But all in all, "I don't think they (any of the children) regret it. We've always asked them what they thought (about foster parenting) . . ."

The Janiaks' medical backgrounds first introduced them to the need for foster parents. Dr. Janiak is the director of the Emergency Department at Toledo Hospital and Mrs. Janiak is a registered nurse, although she's not working at present.

A close friend, who happens to be a pediatrician, told them about a set of twins who were left in the hospital by their young, unwed mother. The babies did have some medical complications, Dr. Janiak says, but they didn't really require hospitalization.

"We said, 'Bring those kids here,' " and they were subsequently put in touch with a county agency and agency representative. As it turns out, the Janiaks didn't get the children — the mother came back into the picture — but an interest for children in need of temporary shelter was born.

Their medical backgrounds have continued to play a role in their foster parenting experiences. "Medical people can play a tremendous role in utilizing the health care system," Dr. Janiak explains. For example, the Janiaks are quick to pick up on medical situations, whether it's some type of illness or a developmental problem. And, what's more, their pediatrician friend has been "willing to donate a lot of time" to the medical care of the children.

Generally, a child falls into the fostering system when there is a problem at a particular home, such as poor living conditions, lack of income, neglect, or other personal/family problems. "Some of the homes are incredibly tragic situations," Dr. Janiak explains.

Sometimes the parents will voluntarily relinquish their children to an agency until they are better able to care for them. In other cases, the children are removed from a home because complaints from neighbors, police or a physician indicate that they are in immediate danger — such as in cases of alleged child abuse or molestation. A social worker will obtain an order to remove the children, and a judicial review will determine if the children should remain out of the home.

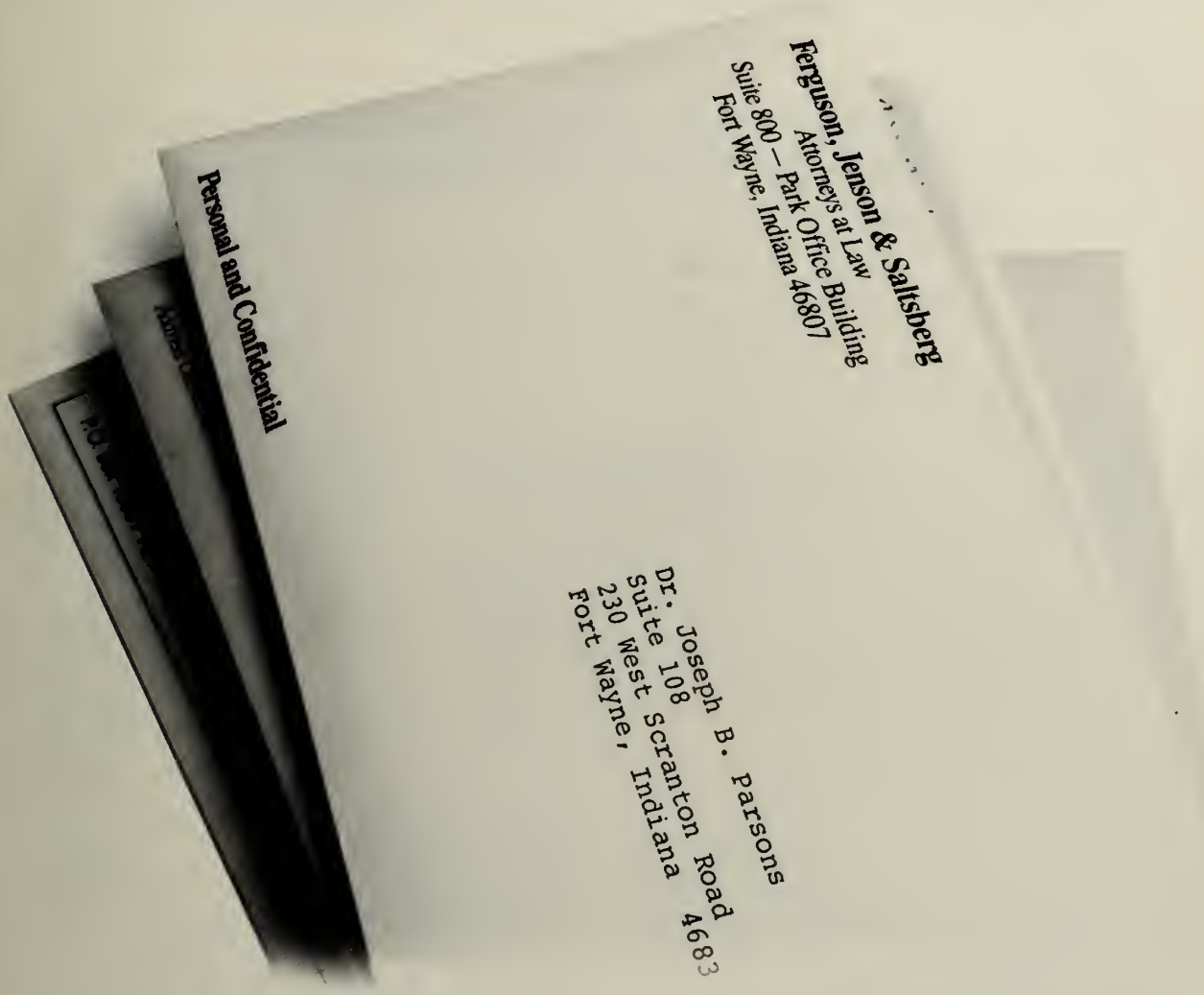
If problems in the home have been resolved to the satisfaction of the court and/or social worker — for example, the parent(s) in question has found a job, completed a detoxification program for substance abuse, or undergone counseling — the child may then be returned to the home. If the problems have not been alleviated, the court may petition for permanent custody, a process which is often time-consuming and costly (both financially and emotionally) — especially in those situations where the parents refuse to relinquish custody, Dr. Janiak points out.

The reality of dealing with incredibly tough situations where parents can be violent, recalcitrant, etc. can be a grueling experience for a social worker, he continues. Consequently, it's very difficult to keep social workers — "they often get burned out," he says. And not only are their jobs emotionally exhausting, but they are also not adequately reimbursed, he adds.

"Child care services are incredibly underfunded," Dr. Janiak continues. And, thus, "we have a system that self-perpetuates mediocrity" — although he's quick to point out that there are some extremely dedicated social workers and agencies.

Most fostering is done through county or private agencies which are licensed and regulated by the state of Ohio. If individuals are interested in foster parenting, they should contact the children services

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"If you're willing to deal with these children and to love them, there's no reason to be frightened of 'special needs' children."

agency in their area, the Janiaks recommend.

The Janiaks' county agency, Wood County Human Services, has a "family feeling" to it, because it's small and there's a strong support system among the foster parents and staff, they say. But agencies in larger counties often have incredibly large caseloads, making it difficult for them to run a close-knit operation.

The screening for both fostering and adoption is similar, although adoption is generally a much costlier endeavor. In both cases, screening includes such things as home inspection, psychological analyses, and other background information. "Fostering is a perfect way to see if you're cut out for adoption," they say. However, "fostering and adoption are whole different ballgames," because when you adopt it means these children become your permanent responsibility.

Many people are reluctant to take that first step into fostering, Mrs. Janiak says, but they probably don't realize that they may choose from many different options. You can choose, for example, to be a foster parent only in emergency situations or for infants who are waiting for the adoption process to be finalized.

In addition, if a particular foster child is not blending in with your family, the child can be returned to the agency, so that another family can be found where the child can fit in more easily. "They (the foster children) have to fit your lifestyle; you don't alter your lifestyle to fit them," Mrs. Janiak emphasizes. This often requires a lot of basic education and guidance; she recalls one 3-year-old foster child who was found every morning sleeping on the floor — "she'd never had a bed before," she explains.

Most children want some kind of direction, structure and rules, Dr. Janiak adds. "You have to direct their interests in achieving a disposition and maintaining that disposition."

"Babies and toddlers are snaps," they both agree, but some older children can be difficult. Some have been in the system so long, "they're so closed, so frightened." They don't want to participate in family activities, and sometimes you feel like "I'm not doing them any good; I can't do anything for them." These are the times you feel like throwing in the towel, they admit. "But the important thing is to have some kind of reaction, even if it's negative," Dr. Janiak says. "You have to say, 'I've done the best I can do . . .' "

The difficulty with older children explains, in part, why they are often so hard to place in foster homes, as well as for adoption. While there is a long list of parents waiting for normal white newborns (the wait is about five years, and the price tag can be considerable), it's a different story for older children and "special needs" children, they point out.

All in all, there's an incredible shortage of foster parents.

"Looking through books of these hard-to-place children is like looking through books of wallpaper patterns — page after page after page," Dr. Janiak says.

"Special needs" children means something different in just about every agency, continues Dr. Janiak. This classification often includes: severely handicapped; children over 10; large sibling groups; children from bad home environments; rape situations; early medical problems; or family histories of medical problems. Sarah, one of their adopted children, was considered "special needs" because there was a history of Huntington's Chorea in her family — although she shows no signs of the illness.

"If you're willing to deal with these children and to love them anyway, there's no reason to be frightened of 'special needs' children," they say. The Janiaks relate a story about one foster child, a severely handicapped infant, "who had such an incredible laugh it made us cry. To know that she was delighting in something, whether it was a mobile above her bed or whatever, it was so moving." The child was eventually adopted.

Fostering has not been as hard as they first imagined: "We thought people would be breathing down our necks," Mrs. Janiak says, but this has never happened. But it does take time and responsibility, just as your own children do. There are out-of-pocket expenses, doctors' appointments, transportation costs,

"Foster parenting is a way of giving something back. You become Mom and Dad in a second — they're like your own."

family visits, and forms to fill out, they explain. And they have a large collection of clothes — in all sizes and shapes — "you learn to be prepared."

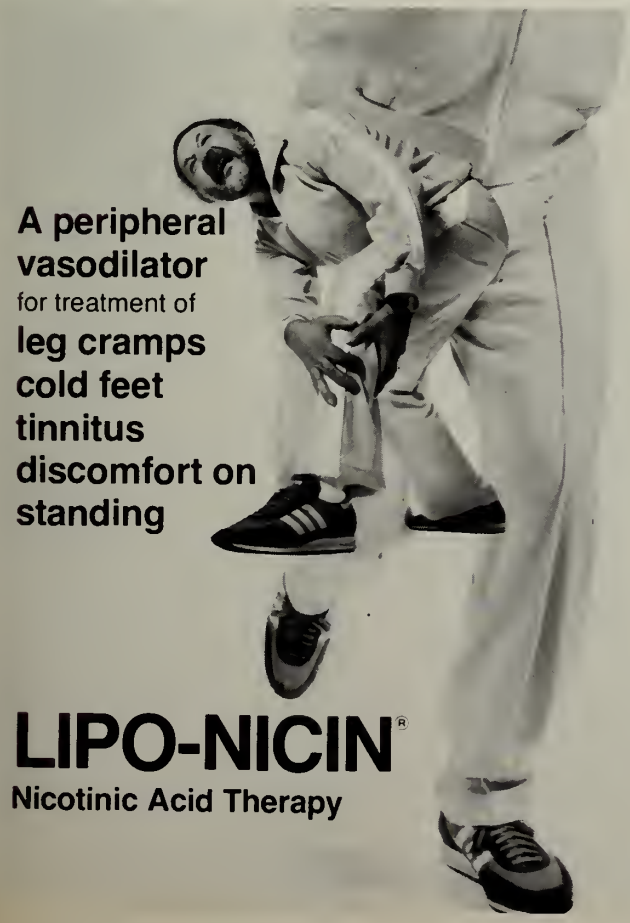
"You can write a check to United Way or to your favorite college . . . this is how we do it," Dr. Janiak says.

"We've been so lucky; we have so much to share," continues Mrs. Janiak. "Foster parenting is a way of giving something back."

"You become Mom and Dad in a second — they're like your own," continues Dr. Janiak. Nothing beats that feeling when they "run up to the door when you get home and their eyes light up." Or when the child hugs you . . . says he loves you . . . that he likes it here . . .

"They're all the corny reasons," they conclude — but over the years, they've been all the *right* reasons, too. **OSMA**

Deborah Athy is the Assistant Editor of **Ohio Medicine.**



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AVAILABLE: Bottles of 100, 500.

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CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB The medical approach to management of pain caused by cancer. "Semin Oncol" 1975, 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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Revised, April 1982. S685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med,* 141:293-300, 1981.

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Star Wars and Real Wars

By Jerald A. Bovino, MD

His thick powerful fingers pushed an errant shock of coarse black hair from his forehead as the nurse helped him onto the stretcher. We proceeded to engage each other in idle conversation — an attempt to distract ourselves from the surgery ahead.

"Do you have any children?"

"I've got a son who's a doctor in Vancouver. He . . .

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"Don't worry about me Doc. I can take it. Spent a year in a German Prisoner of War Camp!"

"No kidding? I never met anyone who did."

The nurse helped the man to the laser, and as the focusing lens was positioned, the story unfolded.

"Was the bombardier on a B-24. Just a kid really — we all were."

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The focused beam of the laser coagulated the blood vessels around his optic nerve with deadly accuracy -- shriveling the juicy neovascular fronds that threatened to let his diabetes steal his precious vision.

"Only four of us made it out before we went into a spin. Six of the crew went down with the plane."

"Was that the first time you jumped with a parachute?"

"You bet! I just pulled that rip cord and prayed."

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"Same sound I heard that day. There was flak explodin' all around us as our parachutes floated down.

Rat-tat-tat went the laser foot pedal. "Same sound I heard that day. There was flak explodin' all around us . . ."

"When we landed I was surrounded by hundreds of irate civilians. Thought they were going to kill me — can't blame 'em of course — what with us dropping bombs on their mothers and children. I was saved at the last minute by a uniformed officer, who helped to fight back the angry mob."

The room quieted as the laser was turned off, and I offered, "Hope that wasn't too bad."

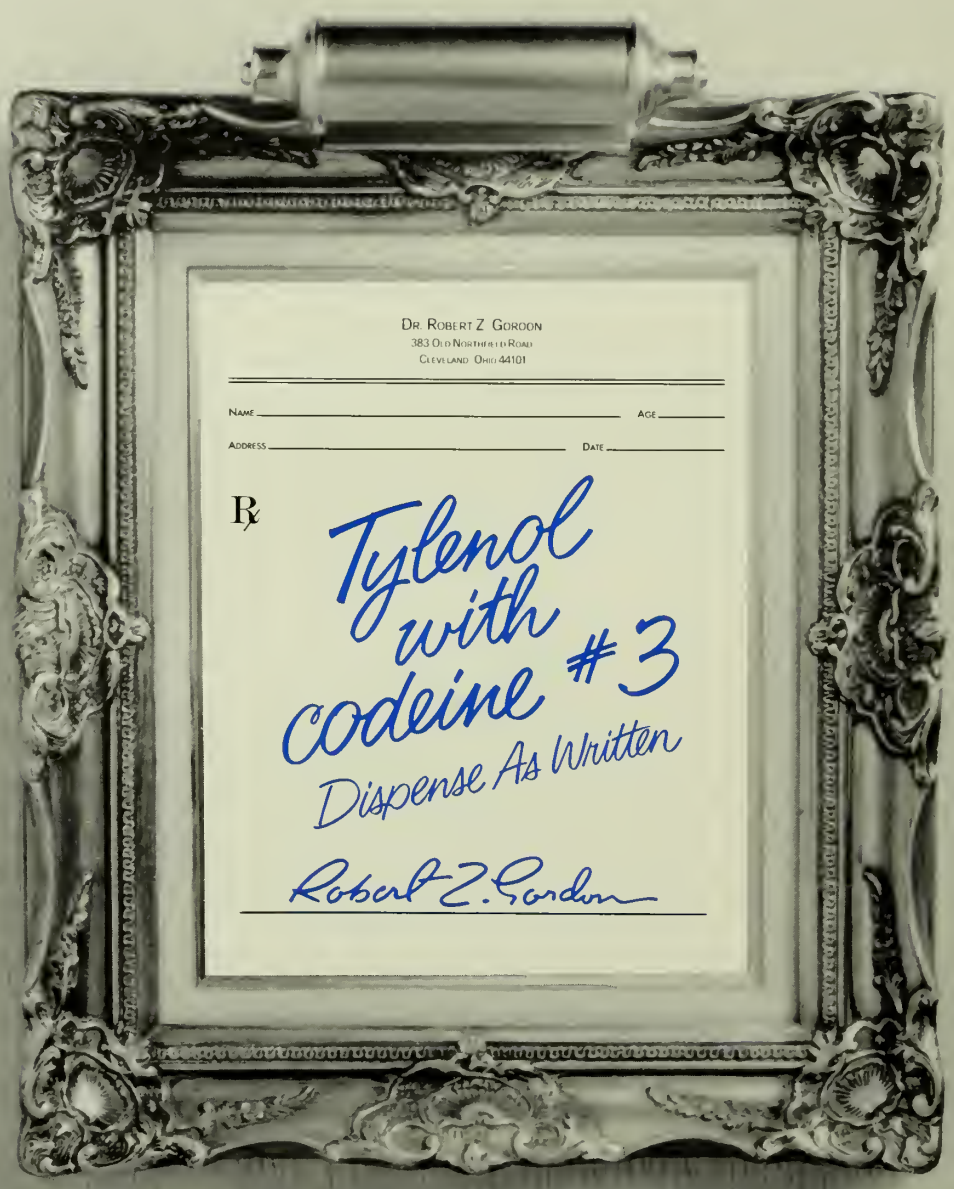
"Don't worry. The doctors can't hurt me. Spent a year in a German Prisoner of War Camp!" OSMA

Jerald A. Bovino, MD, is an ophthalmologist practicing in Toledo.

Genetic drug link

Genetic factors may predispose individuals to a likelihood of drug use, according to a University of Iowa study published in the *Archives of Psychiatry.*

The study compared the effects of biological vs. environmental factors in more than 400 adopted adults, and found that biologic factors were found to lead to antisocial behavior, which, in turn, was associated with drug abuse.



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Drug Testing . . . *continued*

So *is* drug testing the answer?

"Testing and high-tech equipment alone won't solve the problem of drug use in the workplace," argues Mulgrew — and with the amount of controversy which presently surrounds the subject, one can't help but wonder why anyone ever felt it could.

"The problem is that the mechanical and technological aspects of drug testing equipment and procedures are very good if done correctly," says Mulgrew, but, as frequently happens in matters of medicine, ethical issues are not yet clearly resolved.

As a result, the question *should* there be drug testing and who should be tested may very well be a question that remains open for debate for some time to come. **OSMA**

Karen S. Edwards is the Executive Editor of **Ohio Medicine.**

OBITUARIES

CHARLES L. BARRETT, MD, Bellefontaine; Case Western Reserve University School of Medicine, 1933; age 77; died February 6, 1987; member OSMA and AMA.

JOHN U. FAUSTER, JR., MD, Defiance; University of Michigan Medical School, Ann Arbor, MI, 1926; age 86; died February 26, 1987; member OSMA and AMA.

DORENCE HANKINSON, MD, Columbus; Ohio State University College of Medicine, 1929; age 81; died February 24, 1987; member OSMA and AMA.

JAMES G. LEMMON, MD, Bath; Ohio State University College of Medicine, 1915; age 98; died January 21, 1987; member OSMA and AMA.

EDGAR RAY MILLER, MD, Dublin; Ohio State University College of Medicine, 1946; age 87; died February 26, 1987; member OSMA and AMA.

MYRON M. PERLICH, MD, Cleveland; Ohio State University College of Medicine, 1936; age 78; died February 19, 1987; member OSMA and AMA.

WILLIAM J. SHINE, MD, Dayton; Loyola University Stritch School of Medicine, Maywood, IL, 1953; age 61; died January 20, 1987; member OSMA and AMA.

VINCENT J. SIMMON, MD, Potomac, MD; Cornell University Medical College, New York, NY, 1934; age 82; died January 2, 1987; member OSMA and AMA.

LADISLAO WALLERSTEIN, MD, Toledo; Facultad de Medicina de La Habana, La Habana, Cuba, 1952; age 61; died March 1, 1987; member OSMA and AMA.

OSCAR WEISSMAN, MD, Cleveland; State University New York Downstate College of Medicine, Brooklyn, NY, 1932; age 78; died February 13, 1987; member OSMA and AMA.

P.S. WHITELEATHER, MD, Minerva; Ohio State University College of Medicine, 1933; age 84; died February 20, 1987; member OSMA and AMA.

TIBOR WINKLER, MD, Aurora; Medizinische Fakultaet der Ludwig Maximilliams Universitaet, Muenchen Bayerm, Germany, 1949; age 73; died February 13, 1987; member OSMA and AMA.

JOHN W. YOUNG, MD, Toronto, OH; University of Pittsburgh College of Medicine, Pittsburgh, PA, 1925; age 86; died January 31, 1987; member OSMA and AMA.

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The Drug Survey . . . *continued*

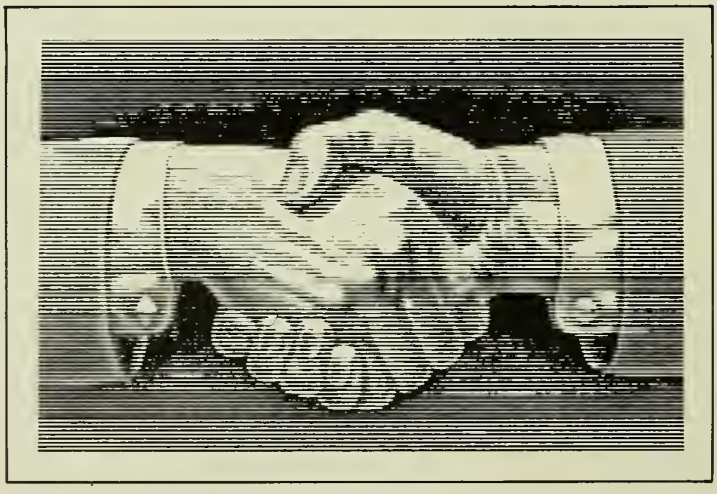
statement, "I believe it is ethical to test a minor patient for drugs at the parents' request and to turn that information over to the parents."

Likewise, more than 70% of the physician respondents indicated that they disagreed or strongly disagreed with the statement, "I believe it is ethical to provide the results of a drug test of a private patient to his or her employer." On the other hand, nearly 60% agreed or strongly agreed with the statement, "I believe I would have an ethical responsibility to alert an employer of a positive drug test of a private patient if that patient's job impacted public health and safety."

On the issue of whether they themselves would submit to drug testing, the respondents were generally positive. More than 75% indicated that they agreed or strongly agreed that they would submit to drug testing if it were required for employment, hospital staff privileges or professional activities, and 73% agreed or strongly agreed that they would voluntarily submit to drug testing.

The results of the OSMA's survey were released at an OSMA-sponsored public forum held recently on the issue of drug testing. The forum — entitled, "Drug Testing: Reliable Deterrent or Threat to Privacy?" — was held in Columbus, on March 4, 1987. — *Carol Wright Mullinax*

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NEUROLEPTIC MALIGNANT SYNDROME

Gilbert L. Wergowske, MD
Thomas James Carmody, MD

The neuroleptic malignant syndrome is a rare but potentially fatal idiosyncratic complication of neuroleptic therapy manifested by pyrexia, altered sensorium, autonomic instability and extrapyramidal signs. Physicians who frequently use neuroleptic agents in treating nausea and emesis, agitation, and psychosis should be aware of its features. The recent apparent success of several different medications in treatment has suggested an explanation of the pathogenesis of this disorder.

Introduction

The earliest reported cases consistent with the neuroleptic malignant syndrome (NMS) appeared in the late 1950s.[1,2] The constellation of signs and symptoms comprising the syndrome was first recognized as a separate clinical entity from the myriad adverse affects and complications of neuroleptic agents by Delay et al in 1960.[3] Until recently, the majority of papers dealing with the "syndrome malin" have appeared in the French medical and psychiatric literature.[4-20] The exact incidence of the syndrome is unknown although an incidence of 0.5-1.0% was reported in a series of several hundred patients receiving haloperidol.[5] Some recent communications support this data.[66] The majority of case reports involve men under 40 years of age, but all ages and both sexes are at risk. Case reports of patients receiving depot parenteral preparations are common,[21-23] but all classes of neuroleptic agents including phenothiazines, thioxanthines and butyrophenones have been implicated.[24-29] The onset of the illness is not related to the dosage or duration of exposure.[30] Some patients who recovered have been rechallenged without recurrence.[31,65] Early speculation regarding the etiology of the syndrome suggested a possible relationship to malignant hyperthermia or acute lethal catatonia, but recent investigations implicate dopamine neurotransmission pathways. The earliest treatments of the syndrome advocated withdrawal of the offending agent, supportive care, anti-Parkinsonian therapy, and anecdotal treatment with muscle relaxants, minor tranquilizers, anticholinergic agents[32] and electroconvulsive therapy.[33,34] Recent successful treatment with amantadine and bromocriptine suggests that a disturbance of dopamine metabolism may be responsible for the development of the syndrome; however, successful treatment with dantrolene raises questions of dopamine's importance or a possible central action of dantrolene.

Clinical Presentation

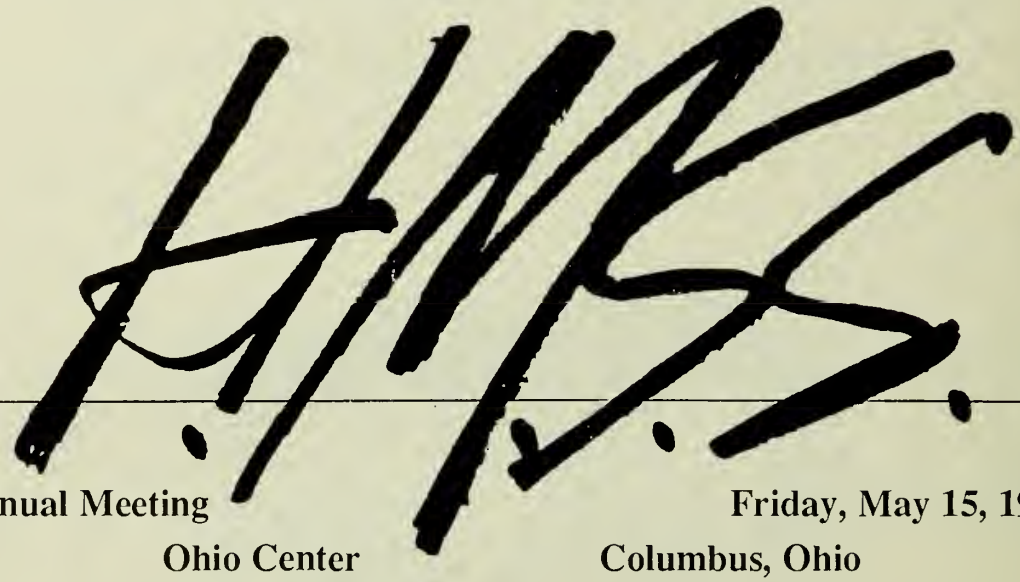
The onset of NMS is heralded by diffuse muscular rigidity, agitation and pyrexia over 24 to 72 hours. Initial alertness and cooperation by the patient precedes rapid deterioration of the level of consciousness. Extrapyramidal signs including rigidity, tremor, dysarthria, dysphagia and dyskinesia have been described. Diaphoresis and sialorrhea may be noted. Tachycardia with labile or sustained hypertension or hypotension may be seen. Urinary incontinence is common.

Laboratory findings are generally nonspecific. Leukocytosis with neutrophilic predominance, elevation of creatine phosphokinase (MM band), and mild elevation of liver function studies have been observed. The electroencephalogram may be normal or show diffuse slowing.[35] The spinal fluid is usually normal but slight lymphocytosis is not uncommon. Computerized tomography of the brain has shown no remarkable changes. Nuclear magnetic resonance and position emission tomography[36] of the brain have not been reported but may be of value when more

Gilbert L. Wergowske, MD, assistant professor of medicine, and Thomas James Carmody, MD, assistant clinical professor of medicine, Department of Medicine, Wright State University School of Medicine and Good Samaritan Hospital in Dayton.

Ohio State Medical Association

HOSPITAL MEDICAL STAFF SECTION



Annual Meeting **Friday, May 15, 1987**

Ohio Center **Columbus, Ohio**

1:00 p.m. Business Meeting

Edmund W. Jones, M.D.; Chairman, OSMA/HMSS, presiding

1:30 p.m. Panel Discussion

"PRO Review Process and Sanctions"

featuring

Dudley F. Briggs, M.D., Chairman, Peer Review Systems Inc.
Barbara Gagel, Regional Administrator of HCFA, Region V
William Todd, J.D., Partner, Porter, Wright, Morris and Arthur
Thomas Stevenson, M.D., Chairman, Central Region Quality Review Committee, PRS, Inc.

3:30 p.m. Review of OSMA Resolutions and Instruction to Delegate

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during prolonged therapy.
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Neuroleptic Malignant Syndrome . . . *continued*

readily available. Results of viral and bacterial studies should be negative. Monitoring creatine phosphokinase levels has been suggested as a means of following the course with decreasing values parallelling a propitious outcome.[37]

Complications are common in NMS with an estimated mortality of 20%.[66] The most serious morbidity includes respiratory failure, thromboembolism, aspiration pneumonia, disseminated intravascular coagulation, hypoglycemia, gastrointestinal bleeding, acute renal failure both with and without rhabdomyolysis and myoglobinuria,[38] cardiac arrhythmias and cardiovascular collapse. Recovery usually occurs in five to 10 days, but may be delayed if depot phenothiazines were given.

The differential diagnosis includes other forms of adverse reaction to neuroleptics, malignant hyperthermia, acute lethal catatonia, sepsis, and central nervous system infectious disease as well as vascular and neoplastic brain disorders. Tetanus, tetany, akinetic mutism, central fever due to trauma or surgery, severe Parkinson's disease, myotonia, intoxication with strychnine or anitcholinergics, spastic paralysis, decerebrate and decorticate rigidity, heat stroke, "locked-in" syndrome, gegenhalten, stiff man syndrome, and hysterical reaction also must be considered. The lengthy differential diagnosis re-emphasizes the need for a high index of suspicion to prevent an undesirable outcome.[39] Neuroleptics should be withdrawn at the first suspicion of NMS.

Pathogenesis and Treatment

The pathogenesis of NMS remains obscure despite recent insight from successful drug therapy. A relationship to malignant hyperthermia has been suggested but several strong distinguishing features are present. Malignant hyperthermia has been shown to be an hereditary disorder of myoplasmic calcium influx.[40] Pancuronium, diazepam and curare do not relieve the muscle spasm in malignant hyperthermia but are effective in the neuroleptic malignant syndrome.[29,41,42] Muscle tissue from a patient who had recovered from NMS developed contracture on exposure to halothane but was not abnormally sensitive to caffeine (a screening test for malignant hyperthermia), and no abnormal response to the fluphenazine was observed in muscle from a patient with malignant hyperthermia.[43,44] Butyrophenone anesthesia has been used without complications in patients prone to malignant hyperthermia.[45] Neuroleptic agents may contribute to heat stroke by inhibiting peripheral mechanisms of heat loss. The diaphoresis and rigidity of NMS suggest a different pathophysiology and help distinguish the syndromes clinically. Acute lethal catatonia, first described by Stauder[46] in the pre-phenothiazine era, may closely mimic the NMS. The presence of initial alertness and cooperation in NMS may help differentiate the disorders.

All of the features of the NMS could be explained on the basis of disordered hypothalamic, basal ganglia, or brain stem function. The corpus striatum and substantia nigra have the highest concentrations of dopamine in the central nervous system and share extensive connections with the thalamus, hypothalamus, and extrapyramidal fibers. A role for dopamine receptor blockade in the pathogenesis of NMS is suggested as cases of the syndrome have been described after the use of dopamine blocking drugs, dopamine depleting drugs,[47-51] and after withdrawal of dopamine agonists.[35,51] Successful treatment of the neuroleptic malignant syndrome with amantadine,[51-55] bromocriptine,[37] and levodopa/carbidopa[35] support this hypothesis. Treatment failure with levodopa/carbidopa has also been reported.[41] The role of dopamine receptor blockade is also sug-

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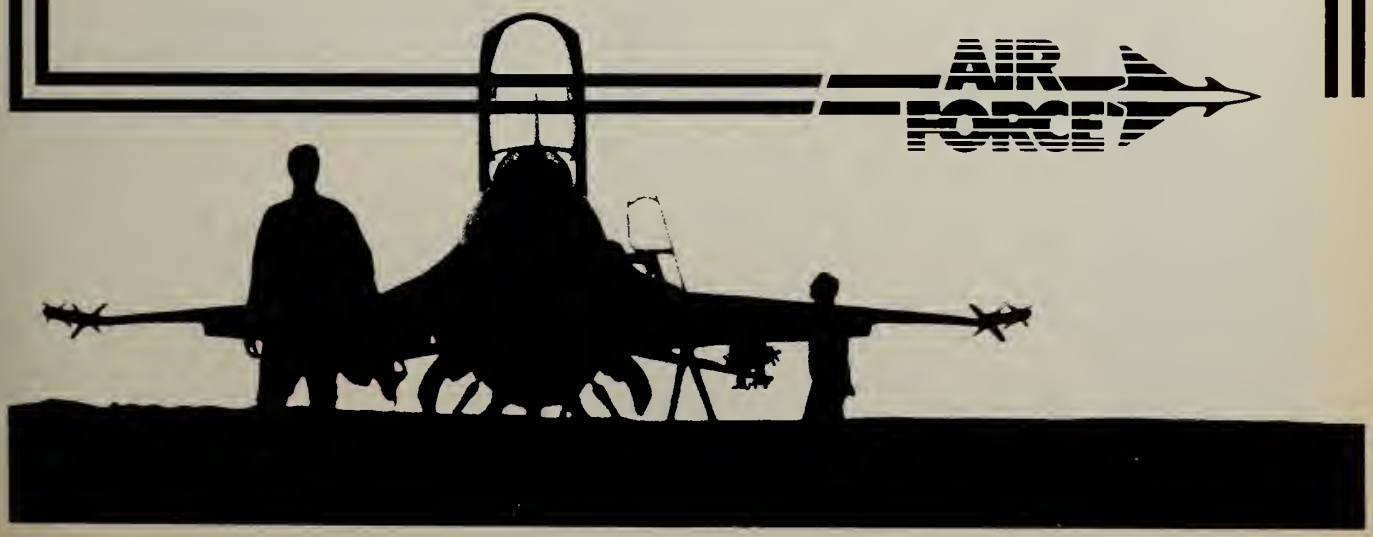
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gested by studies of neurotransmitter and neuroendocrine dysfunction in NMS.[56,57] Histochemical examination of the brain at autopsy has not been reported.[41,51]

Dantrolene has been successfully employed in the treatment of the neuroleptic malignant syndrome.[19,20,58-62] Whether its action is peripheral or secondary to an as yet undescribed central effect remains unclear.[59]

Caution is in order concerning the use of drugs in the therapy of NMS. Adverse reactions to drugs such as dantrolene[63] and bromocriptine[64] warrant thorough familiarization by the physician prior to administration. Withdrawal of the offending agent and supportive care with careful attention to fluid balance remain the mainstays of therapy. Careful observation for respiratory, cardiovascular and renal complications and early intervention is essential. Dialysis cannot remove neuroleptics because of protein binding, but may be helpful with the complication of renal failure.

Conclusion

Hypotheses explaining the pathogenesis of the neuroleptic malignant syndrome have been described but further research is needed. From these theories, several therapies have shown promise in the treatment of this disorder. As most cases resolve spontaneously, withdrawal of the offending agent and supportive measures appear to be the most important clinical management, reserving other therapy for cases that do not improve or deteriorate.[67]

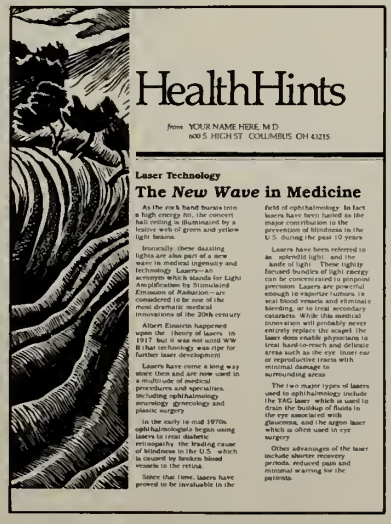
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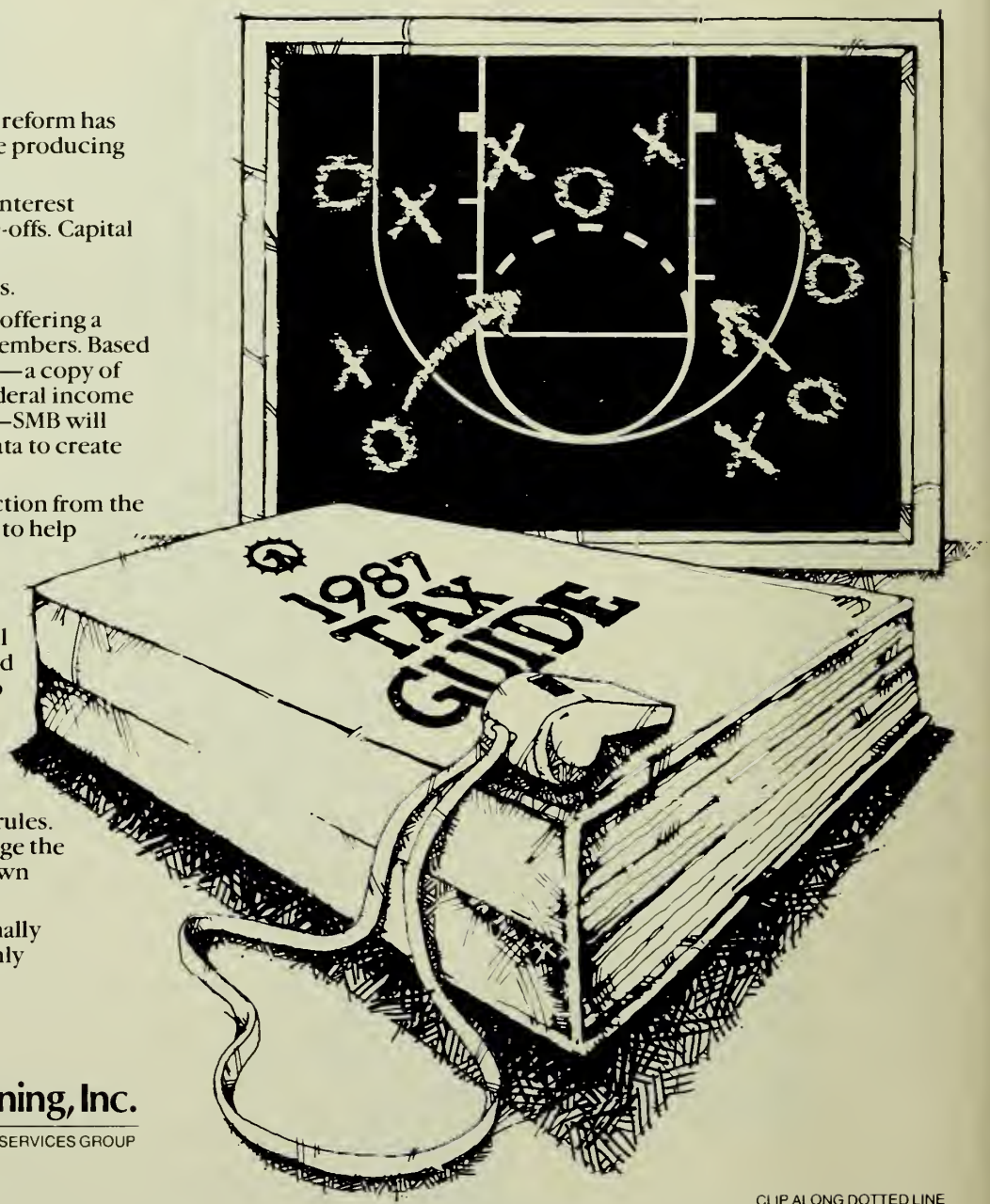
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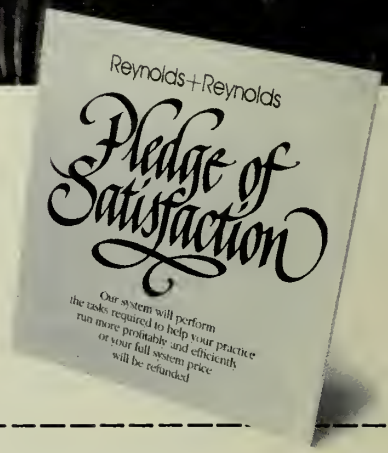
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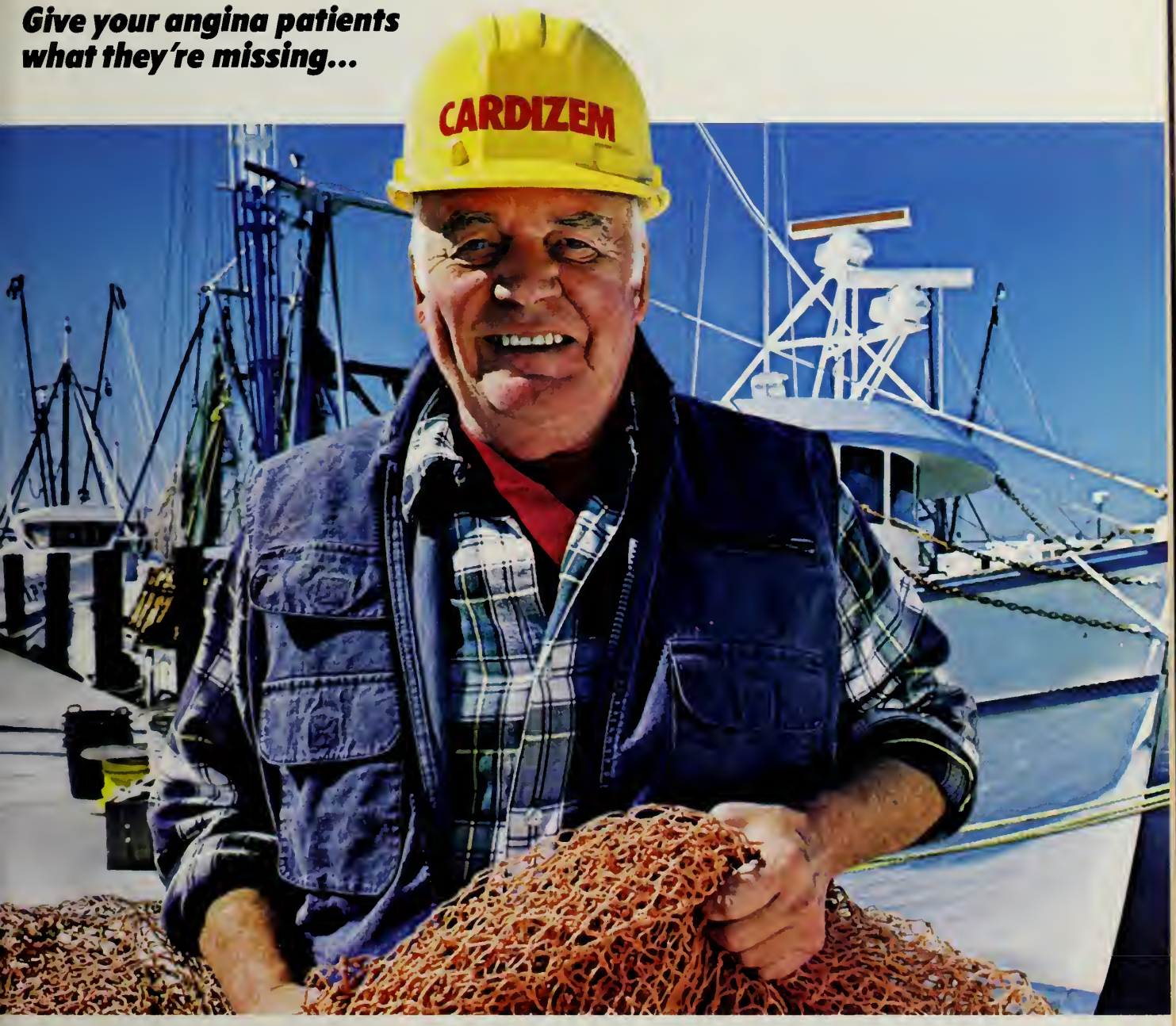
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CONTRAINDICATIONS
CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS
General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration at doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

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AORTOCORONARY BYPASS SURGERY IN PATIENTS 65 YEARS OF AGE AND OLDER

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There is considerable reluctance to recommend major operative procedures for elderly patients. Since most cardiovascular deaths in this country occur in patients over 65 years of age and since most such patients have a number of years of remaining life expectancy, our philosophy has been to evaluate this group for aortocoronary bypass surgery using the same criteria as for younger patients. Our experience in 209 patients with an operative mortality of 8.1% is in accordance with reports in the literature and supports our continued aggressive approach.

Aortocoronary bypass surgery remains at the cornerstone of treatment for severe coronary artery disease after almost two decades of use. With advances in anesthetic and surgical technique and improvement in intraoperative myocardial protection, such procedures have become quite commonplace and safe in larger centers. The increasing age of our population and the trend toward more vigorous lifestyles among senior citizens has, in recent years, drastically changed the composition of the surgical pool as greater numbers of older patients are being considered for major interventions.

Three-fourths of all cardiovascular deaths in the United States occur in patients over 65 years of age.[1] This fact, combined with the tendency to label age as a relative contraindication to any form of surgical therapy, makes an ongoing evaluation of operative risks absolutely necessary.

In a retrospective review of 1,000 consecutive patients undergoing open heart surgery by our group at the Mount Carmel Medical Center in Columbus ending November 1, 1985, aortocoronary bypass was carried out in 209 patients aged 65 years and older. This report analyzes our operative experience in this distinct subgroup of patients.

Materials and Methods

Indications for operation included evolving myocardial ischemia, unstable angina, angina not responding to maximal medical therapy, and left mainstem coronary disease or its anatomic equivalent. Virtually all such patients were accepted for operation regardless of age, in the absence of other medical contraindications or severe and irreversible impairment of ventricular function. Sites selected for grafting were based on

From the Ohio Heart and Thoracic Surgery Center, Inc., Columbus.

both cardiac catheterization and intraoperative findings, with bypass of all major vessels and their larger tributaries with greater than 50-60% narrowing of luminal diameter. All procedures were carried out using standard cardiopulmonary bypass, systemic hypothermia to 28 °C, topical ice slush irrigation of the pericardial cavity, and cold potassium cardioplegia. Saphenous vein grafts were used for complete revascularization in all patients. Peri-operative care was routine and included anti-platelet agents initiated prior to operation whenever possible.

Results

Among the 209 patients, there were 141 men (67%) and 68 women (33%). Mean age for the group was 69.9 years, with a range of 65-86 years; 16 patients were aged 80 years and older. A mean of 3.8 grafts per patient was performed (range 1-7) and associated coronary endarterectomy was carried out on 24 occasions. Five patients had undergone previous cardiac surgery. Cardiac catheterization was performed less than 24 hours previously in 41 patients, and seven patients had undergone percutaneous transluminal coronary angioplasty (PTCA) on a cardiology service an average of 21 days prior to operation.

A total of 35 additional operative procedures were required during the same hospital admission (Table I). There were 17 deaths (11 men, six women, mean age 73 years) for an overall mortality of 8.1%; risk of death was greatest for those patients beyond the seventh decade of life (Table II). One of five patients (20%) undergoing a second cardiac operation died, as did six of 41 (14.6%) having cardiac catheterization within 24 hours, and two of seven (28.6%) with previous PTCA. Cause of death was most commonly cardiac, presumably secondary to sudden or progressive myocardial ischemia (Table III). Hospital stay (date of operation to discharge) in surviving patients ranged from six-72 days; median stay was 10 days for patients under 70 years old and 13 days for patients aged 70 and older.

Discussion

There is no question that operative risks, in terms of both morbidity and mortality, tend to increase with age. Although this study does not claim to be prospective, randomized, or matched, a general index of comparison is provided for the same time period, during which 605 patients under 65 years of age underwent aortocoronary bypass by our group, with an operative mortality of 1.3%. The present operative mortality of 8.1% for the elderly group, however, is certainly in accordance with the 1.6%-14% mortality figures reported for this subset by other investigators.[2-8] In our experience, the particular increase in mortality among those having previous cardiac surgery, PTCA, and recent cardiac catheterization (nine of 17 deaths), occurs in all age groups and may imply more extensive or unstable disease, compared with other patients. Case selection combined with adverse or urgent circumstances are, therefore, major determinants of survival.

The recommendation for cardiac surgery in an elderly patient is frequently difficult, and involves a multidisciplinary decision process. Delays in invasive diagnostics required for subsequent major operative procedures commonly occur, as the aging process is often thought to result in fragile patients beset with multisystem problems. In this regard, the greater need for other operative procedures during the same admission for coronary bypass surgery is clearly apparent in our series and may be reflected in the slightly longer hospital stay for this group. As in other reports,[8] the most common cause of death in our patients was cardiac related, an experience which belies the contention that in the elderly multisystem failure is the primary concern.

There were no particularly unique features in our elderly patients which required modifications in standard intra-operative or post-operative care. Procedural difficulties and post-operative problems were similar to those of younger patients, and the state of the coronary arteries imposed no added technical burden.[2] Advances in cardiac surgery during the past decade, especially in the field of myocardial protection, greatly enhanced the likelihood of a successful outcome.

Most elderly patients still have a substantial life expectancy.[9] In terms of quality of life, we feel strongly that these remaining years are better spent relatively symptom-free and not in the hospital. Despite criticisms regarding physical and psychological trauma, high costs, or late graft failure, aortocoronary bypass is still unmatched in effecting complete myocardial revascularization and in providing durable years of vigorous life. In the absence of contraindications, our experience supports the philosophy that when an adequate trial of medical therapy fails, coronary artery bypass should be pursued for the same indications regardless of age.

Our country as a whole is growing older. Manipulation of risk factors for prevention of coronary disease is commendable, but may only delay the inevitable. We will continue to face the challenge in such difficult situations.

TABLE I
Re-operations — Same Admission

Bleeding/Tamponade	12
Pacemaker Insertion	8
Wound Closure/Debridement	4
Sternal Rewiring	4
Vascular	2
Tracheostomy	2
Miscellaneous	3
Total:	35

TABLE II
Deaths by Age Group

65-69 y. o.	(5/118)	4.2%
70-79 y. o.	(10/ 75)	13.3%
> 80 y. o.	(2/ 16)	12.5%
Total:	(17/209)	8.1%

TABLE III
Cause of Death

Cardiac Arrest	9
Cardiogenic Shock	3
Multisystem Failure	4
Coagulopathy	1
Total	17

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Child/adolescent psychiatrist, Board eligible, preferred certified, to work closely with a multidisciplinary team in an accredited 40-bed child and adolescent psychiatric hospital, an agency of the Michigan Department of Mental Health. We are located in beautiful Traverse City, Michigan. A water and winter wonderland. Traverse City is the cultural and medical center for Northern Michigan. Skiing, fishing, hunting and sailing are at your doorstep. We have an excellent school system and a pollution free, low crime environment. Salary depending upon qualifications to $86,000 with remarkable fringe benefits. Send curriculum vitae and three letters of reference to Arnell Engstrom Children's Center, Box C, Traverse City, Michigan 49684, or call Robert E. Davidson, MD, or Paul Surratt, PhD, at Area Code 616/922-5400.
An Equal Employment Opportunity Employer.

CINCINNATI, OHIO — Physician to take over a well established solo practice in a beautiful small community that is only 30 minutes from downtown Cincinnati. Sale price is favorable and doctor will introduce to patients. The office is located in a beautiful old home with off street parking. Growth potential for a partnership is excellent. Family Practitioners and Internists encouraged to call. Phone: 812-537-4888.

FAMILY PRACTICE OPPORTUNITY. Thriving Family Practice in Ravenna, Ohio is available immediately. Ravenna is in northeast Ohio, Portage County seat, population 12,000; however, the practice draws from the entire county of 130,000. Superb community hospital of 286 beds with almost all specialties available. Present practitioner leaving to assume medical directorship of the hospital and will be available to introduce. Desire FP with Boards or soon to take them. Terms negotiable. Write to: David S. Palmstrom, MD, 250 South Chestnut Street, Ravenna, Ohio 44266, or phone 216-296-9606.

FAMILY PRACTICE — Board or Board Eligible practice opportunity for one or two physicians. Excellent Akron area hospitals. Call 216-253-1329.

FAMILY PRACTICE PHYSICIAN BE/BC WANTED — Senior member of well managed two physician family practice corporation retiring August 1. Well established practice in south suburban Dayton, Ohio. Better-than-competitive salary, benefits, and profit sharing. Partnership opportunity. Ten physician co-op for night/weekend call. Satellite hospital 1.5 and teaching parent hospital 7 miles from office. Full specialty backup. No obstetrics. On site laboratory and x-ray. Outstanding cultural, educational, and recreational opportunities including those in nearby Cincinnati with major league sports. Contact Verne H. Dodson, MD, 1012 East Central Ave., Miamisburg, Ohio 45342. Phone: 513-866-1012.

GENERAL PRACTICE — Retiring physician seeks qualified doctor to take over 40+ year old practice. Will stay on to assist and provide coverage as desired. Modern office with all equipment and ancillary help in place. Combined 565-bed medical facilities. Located on southern Ohio-northern Kentucky border. Good family environment with recreation including boating, camping, hunting, fishing and golfing. Reply Box 128, c/o Ohio Medicine, 600 South High Street, Columbus, OH 43215.

INTERNAL MEDICINE

Our multi-specialty group practice continues to grow. We need Board Certified/Board Eligible internists to meet the needs of our increasing patient population. Both our compensation package and practice environment are attractive. Positions are available in January and July of 1987. Send your C.V. to Search Committee, Group Health Associates, 2915 Clifton Avenue, Cincinnati, OH 45220.

OBERLIN, OHIO 21 person multispecialty group seeks additional BC/BE family physicians, internist, cardiologist, and otolaryngologist. North central Ohio college town serving drawing area of 290,000. Salaried position first year; full shareholder status available in second year. Send CV to Dr. VanDyke, 224 W. Lorain, Oberlin, OH 44074.

OBSTETRICIAN/GYNECOLOGIST (BC/BE). Immediate opening to join an established and growing two-man practice in South Central Ohio. Experience in Ultrasound, Infertility, and Microsurgery desired. Excellent professional and recreational opportunity. Modern 225-bed hospital serving pop. of 60,000+. Send CV to: Center OB-GYN Associates, Inc., PO Box 969, Station A, Chillicothe, OH 45601, 614/773-1133.

OHIO: Emergency Medicine positions ranging from part-time placements to full-time Directorships. Low to high volume hospitals throughout the state. Guaranteed hourly rate plus malpractice insurance. Contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 26, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

Family Practitioner
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Pediatrician
OB/GYN

Needed now to work with an unique, internationally respected rural health system network in Kentucky which includes a hospital, satellite clinics, a home health agency and a school of advanced nursing. This is an Equal Opportunity Employer. A regional medical center is within 20 miles. The practice environment is stimulating – physicians and Advanced Registered Nurse Practitioners work in joint practice teams; interaction with students is encouraged; the rural population presents a great range and intensity of medical problems.

The setting is in heavily-wooded mountains with a moderate 4-season climate. Seven state parks are within 80 miles.

Superior compensation/benefits package includes a guaranteed salary with incentives and malpractice. Call Deborah Pennington COLLECT at 1-502-897-2556.

FOCUS: Healthcare

OHIO, NORTHEAST/CLEVELAND: Staff position for Board Certified/prepared in emergency medicine or other primary care specialties for ED, 8000-32000 patient visits per year. Exc. compensation & benefit pkg: pd. health, life, disability, and dental ins; pension and PS plan; educ. stipend; and vac. Professional liability coverage paid by corp. Advancement to shareholder level for well-qualified individual. Please send CV to PO Box 2600, Lakewood, Ohio 44107.

PHYSICIAN WANTED to join busy, established family practitioner in a lovely college town in Central Ohio. Obstetrics optional. This is a satellite operation of a well-established multispecialty group practice just 18 miles distant. Shareholder status in the parent group available after the first year. Very competitive starting salary with superb fringe benefits. Please reply to PO Box 95, c/o Ohio Medicine, 600 S. High Street, Columbus, OH 43215.

RADIOLOGIST for a busy diagnostic center. General radiology and ultrasound experience in northeast Ohio. Salary negotiable. Reply 361 East Waterloo Road, Akron, Ohio 44319.

SURGEON, BOARD CERTIFIED, FACS, with fellowship in surgical oncology at Memorial-Sloan-Kettering-Cancer Center. Also, with extensive endoscopic, vascular and thoracic surgical experience. Wishes to join group. Reply to PO Box 129, c/o Ohio Medicine, 600 S. High Street, Columbus, OH 43215.

THE FREEDOM TO PRACTICE MEDICINE in an established family practice. You didn't become a physician to deal with the staffing problems or billing. Full-time positions available for bright, personable physicians. Excellent salary benefits and profit sharing. Flexible hours, no on-call duty. Malpractice insurance provided by group. Send CV in confidence to: PO Box 240004, Cleveland, OH 44124.

WESTERN PENNSYLVANIA. BC/BE primary care physicians to join group of four doctors who enjoy working Monday-Friday 8:30-5:00. Optional on-call coverage if desired. Benefits include four weeks vacation, one week CME, 10 holidays, plus malpractice coverage. Facility located one hour east of Pittsburgh suburbs. Must be PA licensed. Call (215) 592-7400 or (1-800) 331-7122 outside PA, or send CV to Liberty Healthcare Corporation, 399 Market Street, Suite 400, Philadelphia, PA 19106.

GULF COAST beautiful Mobile Bay area — substantial guaranteed income with time to enjoy Sunbelt lifestyle. BE/BC — Family Physicians, IM, or EM to join medical group with multiple urgent care/family practice clinics. Contact: Ms. Vogel, 1168 S. Beltline Highway, Mobile, Alabama 36609, (205) 343-5263.

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OFFICE FOR RENT in established medical building in Wooster. Good location. Call Dr. Brant 216-262-4901 days.

OFFICE SPACE FOR LEASE — Akron (Fairlawn) Ohio. 2500 square feet. Ideally suited for one or two physicians. Patient reception area, treatment room, six exam rooms, three private offices, lab. Call 216-253-1329.

Position Wanted

BOARD CERTIFIED CARDIOLOGIST (internist) Invasive-Non Invasive, Ohio licensed, wishes to join group, hospital, industry, company, etc. Reply to Box 125, c/o Ohio Medicine, 600 S. High St., Columbus, OH 43215.

POSITION DESIRED. 58 years of B.E. OB-Gyn, Licensed in Ohio. Looking for a position in any institution. Phone area code 614-353-1553 or 614-858-6213.

Practice for sale

MEDICAL PRACTICE FOR SALE — Active ENT & allergy practice for sale. Solo physician retiring NE Ohio. Excellent hospital facilities. Reply to: Attorney Ralph Higgins, Westview Towers, 21010 Center Ridge Road, Rocky River, OH 44116.

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PROPERTY MANAGEMENT. Eliminate costly property responsibility. Substitute full-service property management. Improve earnings, increase asset value. Thirty years experience serving all Ohio and the Midwest with professional property management for apartments, condominiums, and commercial property. Detailed, current reports submitted punctually. For information or to request meeting, phone collect, J. Schwarz, President, (216) 461-4575. MANAGEMENT ONE, 1450 SOM Center Rd, Mayfield Heights, Ohio 44124.

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Colleagues in the News . . . *continued*

Myron H. Powelson, MD, Zanesville, has been elected chief of staff of the executive committee of Bethesda Hospital for 1987.

William Richter, MD, Defiance, has been appointed to a four-year term on the Defiance Hospital Board of Trustees.

Gurdev S. Purewal, MD, an orthopedic surgeon from Weirton, has been elected president of the medical-dental staff of Weirton Medical Center.

Anthony J. Rich, MD, a family practitioner from East Palestine, has been named Columbiana County Coroner.

Bruce F. Rothmann, MD, Akron, has been elected Trustee of the Akron Community Foundation and has been appointed to the Foundation's Distribution Committee.

Richard Santangelo, MD, a Cincinnati pediatrician, has been elected president of the medical-dental staff at Children's Hospital Medical Center.

Morton Sass, MD, Cleveland, Department of Internal Medicine, has been elected president-elect of the Huron Road Hospital.

F. Jane Shaffer, MD, a Toronto internist, has been elected president of the Ohio Valley Hospital medical staff.

Howard C. Smith, MD, a Sandusky gynecologist, has been elected president of the Providence Hospital medical staff for 1987.

R. C. Soriano, MD, Napoleon, has been named Henry County Coroner.

William E. Sovik, MD, a retired ophthalmologist from Youngstown, has been named the Mahoning County Medical Society's Doctor of the Year for 1986.

J. Harry Stagaman, MD, a family practitioner, has been re-elected president of the medical staff at Cincinnati's Our Lady of Mercy Hospital.

Sherry Stanley, MD, Dayton, medical director of Miami Valley Hospital's SeniorCare geriatric program, has been appointed for a three-year term to the Governor's Task Force on Alzheimer's Disease by Governor Richard Celeste.

Frank J. Waickman, MD, a pediatrician from Cuyahoga Falls, received the Rinkel Award for Excellence in Teaching from the American Academy of Environmental Medicine.

Jeffrey Wacksman, MD, a Cincinnati urologist, has been awarded the J. Thilby Research Award from the North Central Section of the American Urological Association.

John Waterson, MD, PhD, Hudson, has been appointed to the Scientific Advisory Committee of the Lowe's Syndrome Association, to the University of Akron's Institute of Biomedical Research, and to the Midwest Regional Genetics Network. Dr. Waterson is the director of Genetics at Children's Hospital Medical Center of Akron.

John Wright, MD, Lorain, has been elected chief of staff of Lorain Community Hospital.

Kenneth L. Wehr, MD, Hamilton, has been elected president of the medical staff of Fort Hamilton-Hughes Memorial Hospital. Dr. Wehr specializes in internal and pulmonary medicine.

COLLEAGUES IN THE NEWS

Kamal Barsoum, MD, Cleveland, has been elected president of the Community Hospital of Bedford medical staff for 1987.

Daniel Bethem, MD, an orthopedic surgeon from Cuyahoga Falls, and **William Schrader, MD,** a Cincinnati orthopedic surgery resident, have received the Russell A. Hibbs Award for outstanding research at the 1986 Scoliosis Research Society Meeting.

Kenneth J. Bescak, MD, a Lorain cardiologist, has been named president of the Lorain County Medical Society for 1987.

John D. Botti, MD, Canton, has been installed as president of the medical staff of Timken Mercy Medical Center for 1987.

Paul Buehrer, MD, Mansfield, has been elected president of the Mansfield General Hospital medical staff for 1987.

William Daehler, MD, Portsmouth, has been honored as the team physician for the 1961 state championship basketball team, the Portsmouth Trojans.

Richard Davis, MD, Zanesville, has been elected 1987 medical staff president of the Good Samaritan Medical Center.

Mortimer Dolman, MD, Gahanna, has been appointed new medical director of the Heritage House in Columbus.

Michael E. Ervin, MD, Kettering, medical director of Miami Valley Hospital's Emergency Trauma Center, has been named medical director of Health Maintenance Plan in Dayton.

Milton B. Good, MD, Cleveland, chief of the neurology section, has been elected president of the Fairview General Hospital medical staff for 1987.

Tibor J. Greenwalt, MD, of Wyoming, director of the Hoxworth Blood Center at the University of Cincinnati, has been asked to serve on the National Heart, Lung and Blood Advisory Council of the National Institutes of Health in Washington, DC.

James R. Hodge, MD, Akron, has been elected vice president of the Central Neuropsychiatric Association. Dr. Hodge is professor and chairman of the Department of Psychiatry at Northeastern Ohio Universities College of Medicine.

Carl Jenkins, MD, Springfield, an orthopedic and family practice physician, has been elected president of the Board of Health of the Springfield City Health District for 1987.

Isaac Knoll, MD, Miami Beach, has been named president of the South Florida Chapter American Physicians Fellowship Inc. for Medicine in Israel.

William Krall, MD, a Fairfield internist, has been named 1987 chief of staff at Mercy Hospital in Fairfield.

Charles S. Li, MD, a plastic surgeon from Parma, has been re-elected president of the Parma Community General Hospital medical staff.

Antonio S. Licata, MD, a general surgeon from Steubenville, has been elected president of the Hancock County Medical Society.

John R. Madison, MD, Salem, has been elected president of the Salem Community Hospital medical staff for 1987.

Delbert Mason, MD, Oberlin, has been elected chairman of the Lorain County Services Board.

Frank Mayfield, MD, Cincinnati; **Frank Nulson, MD,** Cleveland; and **Robert White, MD,** Cleveland, are included in a new book by Paul C. Bucy, MD — *Neurological Giants.* The book is being published by Elsevier printers.

Steven K. McCullough, MD, Bluffton, has been named 1987 chief of staff for Bluffton Community Hospital.

William S. Owen, MD, a Warren neurosurgeon, has been re-elected president of the St. Joseph Riverside Hospital medical staff for 1987.

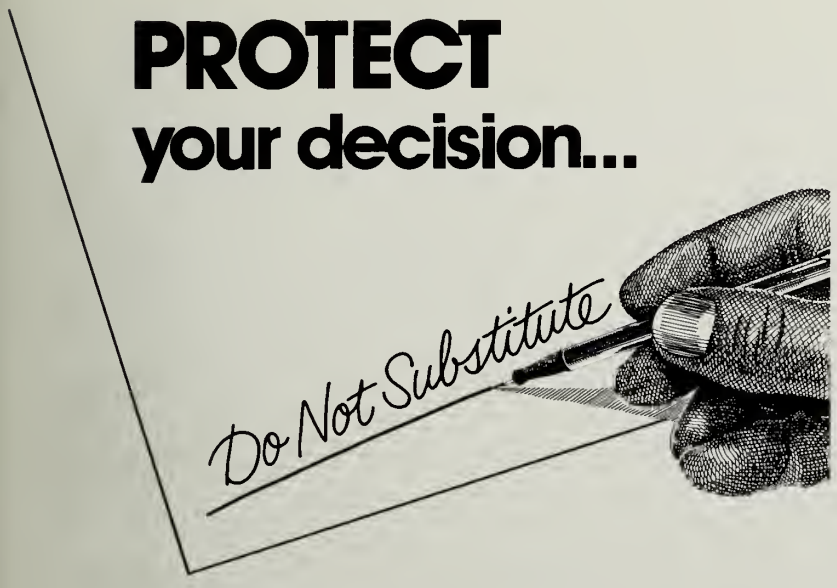
Peter Paladin, MD, a Parma pediatrician, has been selected to serve on the Parma School Board.

continued on page 363

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- **satisfies patients with a good morning after a good night's sleep**
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The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

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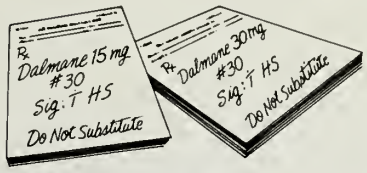
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sleep that satisfies

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capsules



References: **1.** Zimmermon AM. *Curr Ther Res 13*:18-22, Jan 1971. **2.** Amrein R, *et al. Drugs Exp Clin Res 9* (1):85-99, 1983. **3.** Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther 21*:355-361, Mar 1977.



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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl, pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported; abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precaution: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.
Adults: 30 mg usual dosage; 15 mg may suffice in some patients.
Elderly or debilitated patients: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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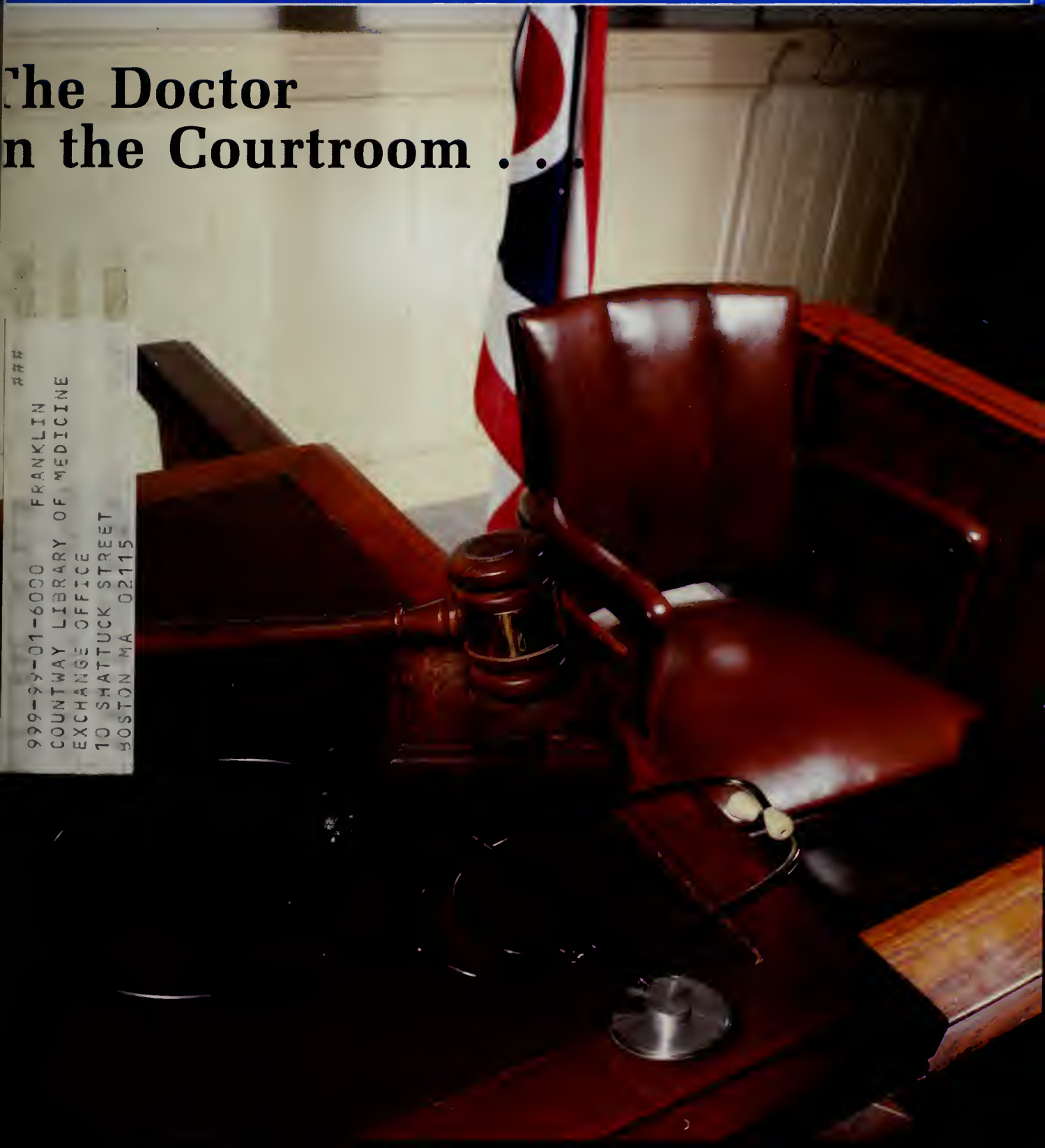
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Please see adjacent page for references and summary of product information.

OHIO Medicine

JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

VOL. 83, NO. 6 JUNE 1987



The Doctor in the Courtroom . . .

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good mornings
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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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FROM THE EDITOR

The Doctor in the Courtroom

Malpractice is one of those subjects that recurs again and again in *OHIO Medicine* — and finding fresh approaches to the topic can, at times, be frustrating. This month, however, we think we've come up with an angle that should be as helpful as it is informative.

Our first article, for example, takes a look at what you can do to stay out of the courtroom — without getting mired down in long-winded consent forms and medical records that tell more about a patient than you — or anyone, for that matter — really need to know.

In the next article, Associate Editor (now Associate Director of the Department of Communications) Susan Porter assumes a "worst-case scenario," and explains what happens if you *are* sued. Step-by-step she takes you through the process — from receiving notification of the suit to its settlement — including a handy list of courtroom "dos and don'ts" which you may want to hang onto — just in case *your* day in court ever arrives.

Our last look at the subject is provided by The Honorable Lawrence Grey, Judge of the Fourth Appellate District in Athens. Judge Grey is a frequent contributor to *OHIO Medicine,* and this issue he has prepared an article which may help you (and your attorney) decide whether or not an unfavorable decision in a malpractice case can be appealed — and, if so, how to proceed.

In unrelated matters this month, two librarians at the Health Sciences Library at Ohio State University have written an informative article which shows how you can tap into the wealth of medical literature available through sophisticated "information systems" in place at most medical libraries. You'll be amazed at the access available to you.

On the lighter side, you'll no doubt enjoy the wonderful "pearls of wisdom" that have come from the mouths of OSMA members through the years. Collected and compiled by OSMA's Executive Director Herb Gillen, you'll find much "food for thought" — and laughter — contained in the article. Don't miss it!

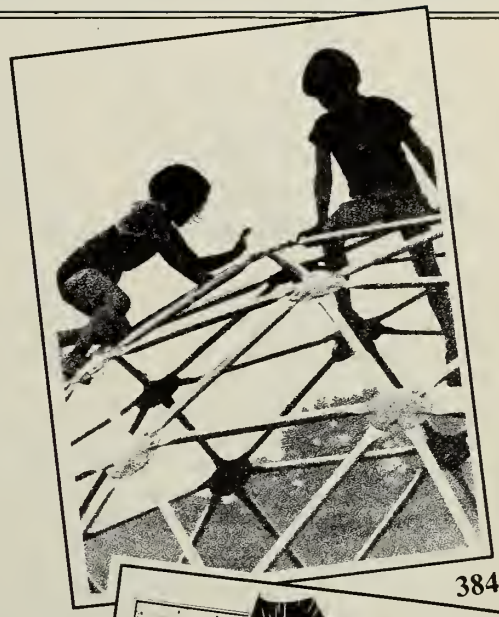
This month's "Ohio Medi-scene" section covers a wide range of topics — from how to recognize child abuse to a story on the New Jersey Impaired Physician's Program — the first in the country to hire a full-time medical director. Pharmacist Robert Reid has also contributed product information on Retrovir, the new drug that's being used to treat AIDS.

Finally, a small housekeeping matter. As has already been mentioned, Susan Porter, long-time associate editor of *OHIO Medicine* will be leaving the OSMA this month to pursue other writing interests. Assistant Editor Deborah Athy has stepped into the role of associate editor, and we know you'll enjoy her work as much as ever. Our heartfelt congratulations to both . . .

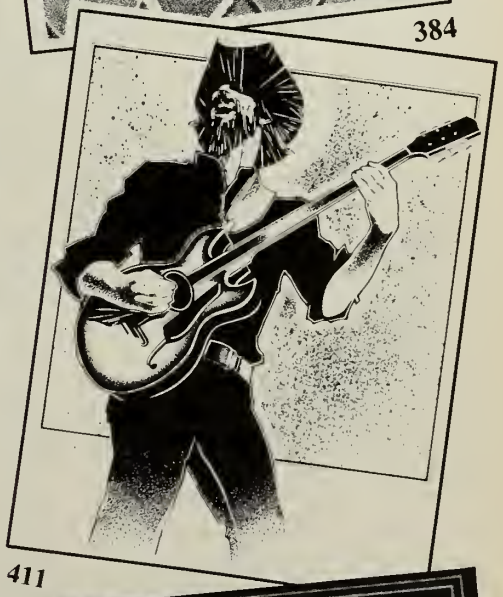
Karen S. Edwards

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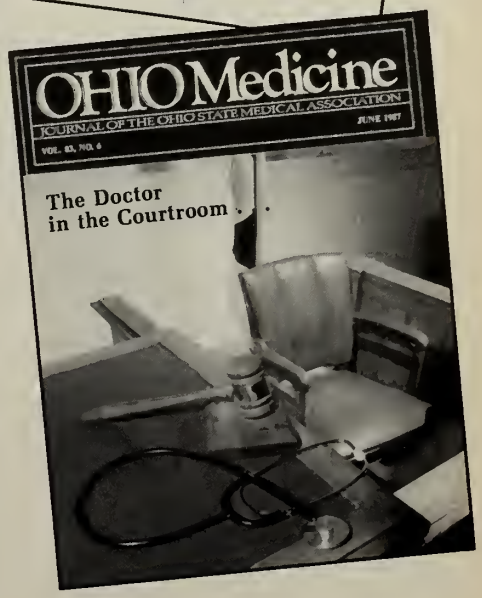
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OUR COVER

This month's cover was photographed by freelance artist-photographer Larry Hamill.

OHIO Medicine *extends its appreciation to Judge John D. Holschuh and his staff for allowing us to photograph inside his courtroom.*

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LETTERS TO THE EDITOR

DRGs . . . an impediment

To the Editor:

I write in reply to Dr. Pescovitz's letter in the March issue in which he makes a fervent plea not to consider the DRG system as an impediment to the delivery of quality medical care. You will recall that Dr. Pescovitz is a paid bureaucrat who functions as the medical director of the PRO. As a family practitioner in a semi-rural area, I find that Dr. Pescovitz's PRO operates to the daily detriment of my elderly patients.

There are many examples:

The elderly patient who lives alone and is too confused to prepare himself or herself for the necessary outpatient tests. True, the tests can be done as an outpatient — but not properly done. — or

The elderly patient who lives alone, does not drive and is 50+ miles from the hospital. — or

The elderly patient who is confused, slowly dying of cancer and who is admitted to the hospital over the weekend until nursing home placement can be found. Admission denied.

Then we have the Medicaid patient who is admitted on a Friday afternoon (after PRO closing hours) with a hot gall bladder. Surgery is done, the patient is relieved of pain and suffering, and the admission is denied because of a lack of prior authorization.

Dr. Pescovitz's parent organization has issued a rule book entitled, *Physician's Guide to the Understanding of DRGs.* Page 5 says, "Symptoms are to be used as a principal diagnosis only if no underlying cause has been diagnosed." An elderly lady has a change in her cardiac rhythm and faints. Dr. Pescovitz insists that Syncope is the principal diagnosis rather than the underlying cardiac cause.

The rule book says, "A complication which occasioned admission to the hospital may be designated as the principal diagnosis." A patient who has been in congestive failure for years worsens and enters the hospital with pulmonary edema. Dr. Pescovitz refuses to accept Pulmonary Edema and insists that the diagnosis is "Congestive Failure."

A patient enters in renal failure. The urologist does bilateral retrogrades and no obstruction is found. Dr. Pescovitz insists that the principal diagnosis is "Ureteral Calculus."

The PRO has issued a directive which forbids the implantation of a permanent pacemaker in a patient with a "prolonged P-R interval with artrial fibrillation." I have never been able to identify this entity. When I asked Dr. Pescovitz, he says, "I'm a surgeon, ask a cardiologist." I've been asking Medco Peer Review and Peer Review Systems, Inc. for six months with no reply.

This is just a portion of the "other side of the coin." Things are not as great and good as Dr. Pescovitz's letter would lead you to believe.

Sincerely,
J.R. Sheets, MD
Scioto Family Practice, Inc.
Portsmouth

. . . or not an impediment?

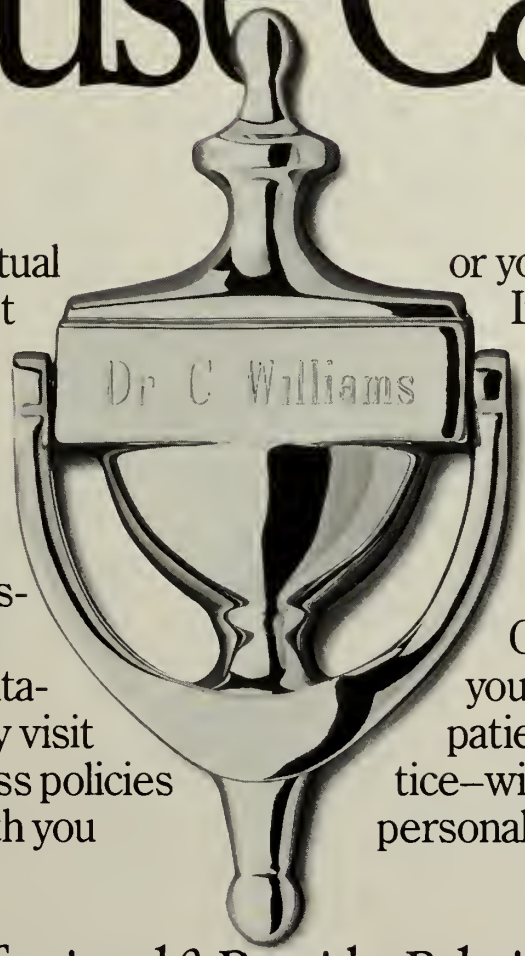
To the Editor:

Dr. Sheets sent me a copy of his letter to the editor dated March 30, 1987. I have had much communication with Dr. Sheets, as well as with the PRS in Columbus about his concerns. His letter, of course, is a series of misconceptions, ignorance and significant misquoting. For example, whenever I go out to speak to organizations, medical societies, hospital staffs and physicians, I indicate at the start that I am a paid part-time medical director. At the same time, I have a busy, active practice of general surgery. So, when he called me a "paid bureaucrat," it would be funny if it were not almost insulting. I have also pointed out to him that all of our physician advisers are paid and are also qualified in their subspecialty and general fields of medicine and are in active practice. I have indicated to him frequently that we are bound by federal regulations, especially in situations where admissions are being done for "work-up" or what can be attributed to as a "social reason," where in the opinion of the physician, the patient can not get back and forth for outpatient testing. The point about an elderly patient being admitted to the hospital until nursing home placement can be found has been specifically identified as a social service problem and is not an indication for admission to the hospital. We, too, are faced with similar problems in our practices. We have warmth and understanding for such situations, but we do not have the ability to allow for admission to the hospital while arrangements are being made for nursing home placement.

His comment about a Medicaid patient admitted with a "hot gall bladder" is completely inaccurate. An emergency admission does not require a preadmission authorization for admission. The type of case which he alludes to in his paragraph is appropriate for

continued on page 370

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admission and we do not deny it. The several specific cases which he is unhappy with are coding changes. They are reviewed by our coding experts on our staff. Dr. Sheets just refuses to believe that perhaps others have a better knowledge of coding than he.

As far as a patient entering in renal failure, we felt that the admitting diagnosis was renal calculus. We have had a long "cross-letter writing discussion" about this case. In this specific case, there is a pathology report indicating a calculus, and there is a note in the record indicating a calculus. This case is still under review by PRS in Columbus, at my request.

As far as my referring to his concern about saying, "I am a surgeon, ask a cardiologist," this is completely inaccurate. Of course I am a surgeon and not a cardiologist. I simply do not speak like this to the physicians in our Medco area. I refer all specialty concerns which are out of my area of expertise to the appropriate people. The P-R interval was a misprint from HCFA and should have been R-R interval. Dr. Sheets did pick up this error. PRS in Columbus is addressing this. He is upset, I believe, because the wheels move slowly to correct this "typo."

Before you publish such a letter which is inflammatory and inaccurate, I suggest that you have Mr. Fry discuss specific cases, with me and with Dr. William Smith, the Vice President of Affairs of PRS in Columbus.

I will be glad to discuss this with you further at any time.

Sincerely,
Harold Pescovitz, MD
Medical Director
Medco Peer Review, Inc.
Cincinnati

DRGs . . . one last word

To the Editor:

After reading Dr. Harold Pescovitz's letter objecting to the fact that "DRGs affect quality" which appeared in a previous OSMAgram issue, I feel constrained to write these lines. Among other things, he has written that "it is yet to be shown that there has been an increase in eye complications with shift to outpatient cataract surgery." I just want to mention the experience of one of my patients. He was admitted in the morning and discharged the same afternoon. Living alone, this elderly patient developed postoperative urinary retention and remained in this state until the next morning, restless but unable to find a telephone number to call for help, his one eye patched and the other with poor vision due to cataract (awaiting another outpatient surgery). When eventually he was brought to the ER and obtained relief after catheterization, he was reluctant to be admitted, saying "the new system does not allow for hospital stay." It is not my intention to catalogue all such instances, but the factual position is that contrary to what Dr. Pescovitz has written, the DRG system has resulted in poor patient care.

I entirely agree with him when he says that "hospitals have not lost under the DRG system, as a matter of fact, they have been profitable." Neither has the federal government. The only losers have been these Medicare "beneficiaries." They even are ignorant of the fact that there exists such an entity as Medco Peer Review Inc., located in the ivory tower of Cincinnati.

Sincerely,
R. Ghani, MD
Cincinnati

Training physicians about alcoholism

To the Editor:

Mount Carmel Family Practice Residency Program held its semi-annual Family Relations Seminar on March 25, 1987. As part of an ongoing series exploring current issues in medicine, the OSMA was invited to present their "Physician's Effectiveness Program." Mr. Robert Clinger, OSMA staff person to the program, presented the seven principles of the program in identifying and helping impaired physicians.

The keynote speaker was Dr. William Powell, who spoke about his personal struggle and recovery from impairment. Dr. Powell made the following observations during his talk:

> "Starting with the demands of training and the high levels of expectations, the physician is in a very vulnerable position. Neglecting the family and personal relationships in the pursuit of excellence, the physician may find substance abuse a convenient way to cope. Practicing in a high tech, high intensity, and high liability environment places the physician at high risk for impairment. Lacking information about the problems of impairment places the physician and spouse at a disadvantage in making early identification. Since clinical skills are usually the last to go, it is imperative that medical families be educated for early detection and intervention."

Dr. and Mrs. Powell's willingness to share their insights and personal struggles were inspirational.

It is our hope the OSMA will be

continued on page 372



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CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.
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Letters to the Editor . . . *continued*

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Michael Kirwin, MD
Associate Director
Mount Carmel Family
Practice Residency Program

Contract medicine handbook available through CMA

To the Editor:

I have always been impressed by those issues of *OHIO Medicine* which cross my desk, and the February 1987 edition was certainly no exception. I particularly congratulate Susan Porter on her excellent presentation of a complicated topic in "Contract Medicine — Before You Sign on the Bottom Line." The California Medical Association, having reviewed some 800 different physician contracts, is happy to share its experience with other state medical associations. I hope my comments incorporated into the article proved helpful to Ohio physicians.

Ms. Porter quoted from the California Medical Association's revised *Physician's Contracting Handbook* in her article. The CMA has received hundreds of requests for the *Handbook* from outside California, and makes the *Handbook* available to non-CMA members. To order a revised *Physician's Contracting Handbook,* physicians and other interested parties should send a check, payable to Sutter Publications, Inc. at P.O. Box 7690, San Francisco, California 94120-7690. The *Handbook* is available for $10.00 per copy, tax and handling included.

Sincerely,
Elizabeth A. Snelson
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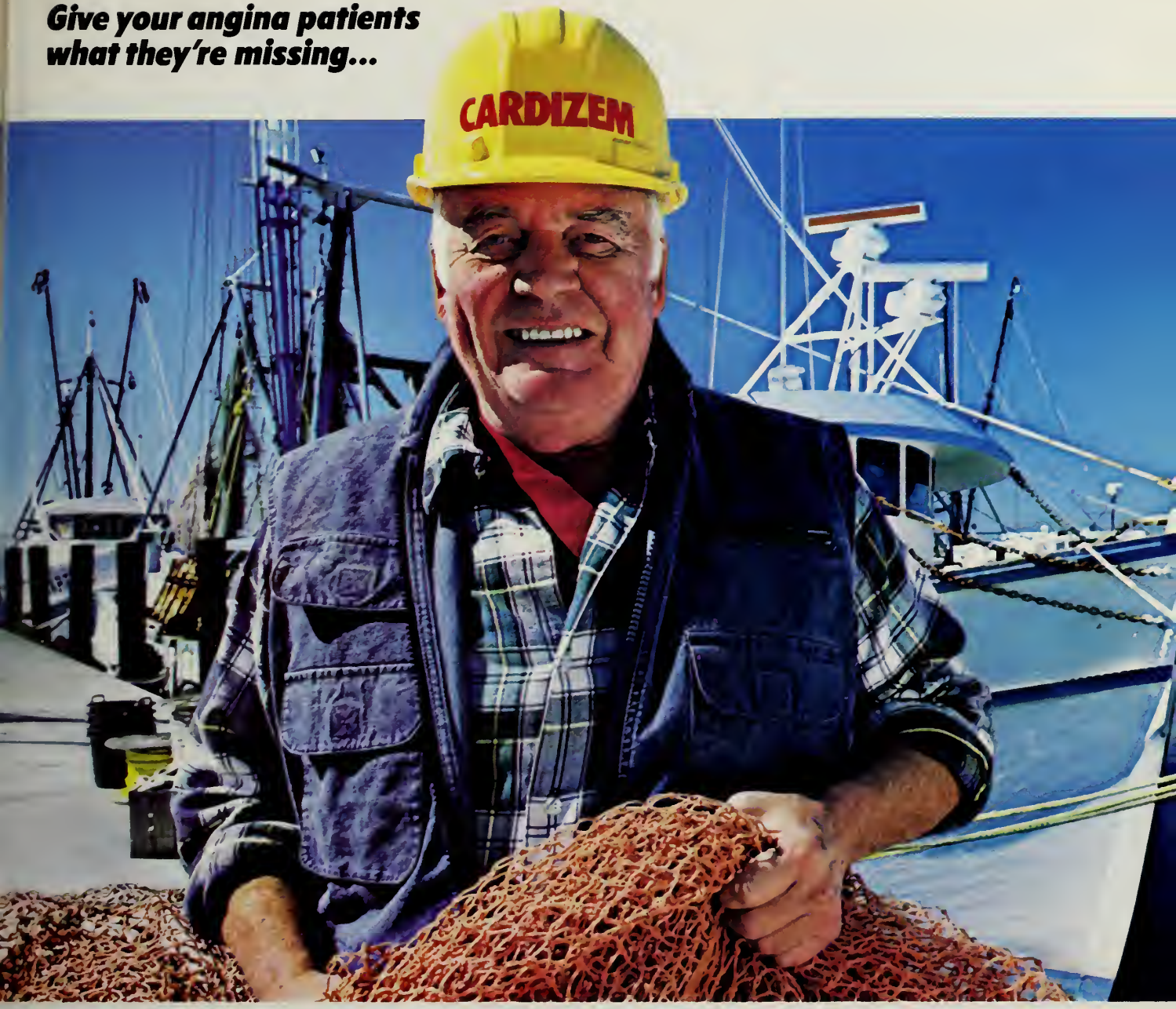
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CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS
General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 7/86

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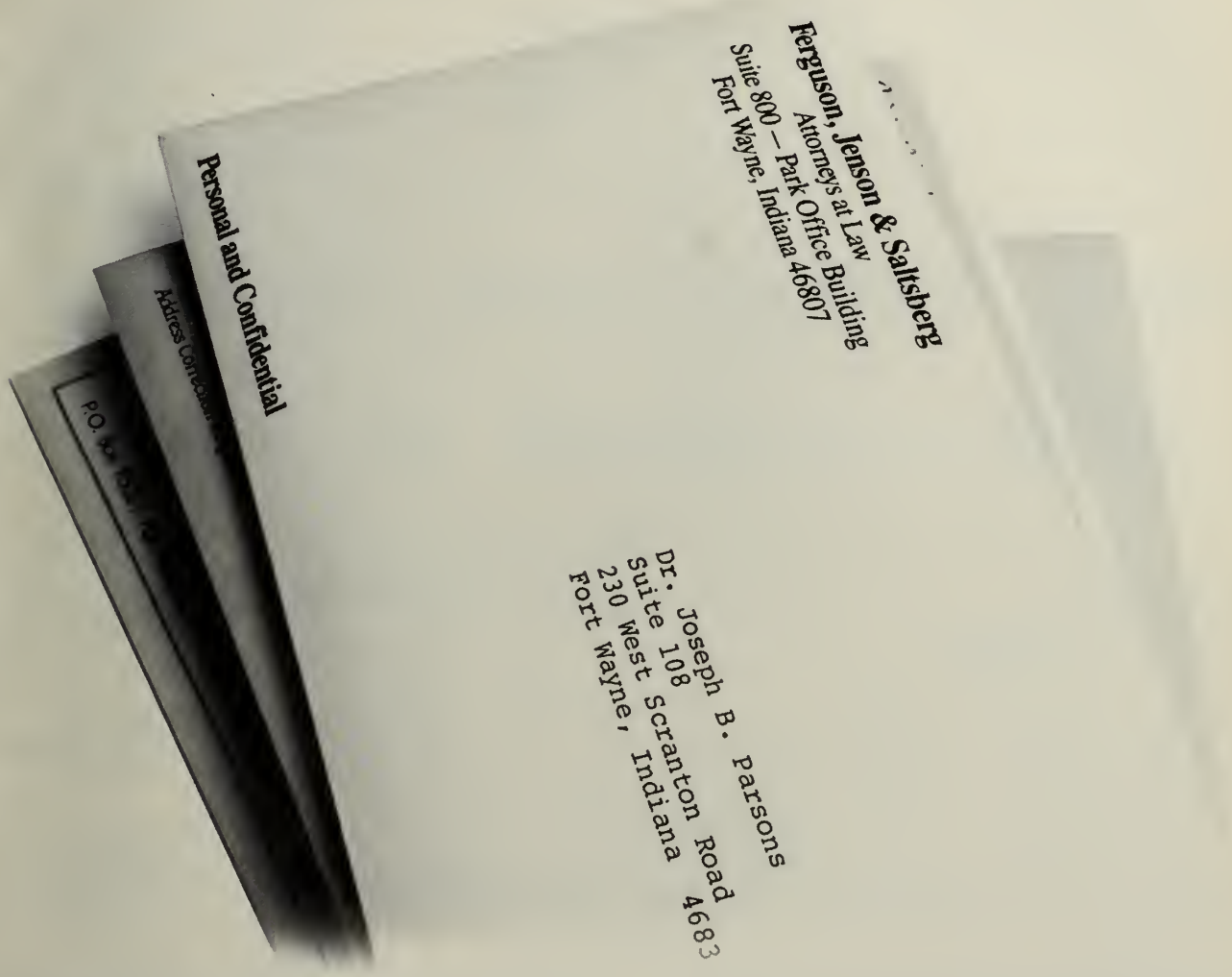
References: ***1.*** *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983, 106(6):1341-1347.* ***2.*** *Shapiro W: Calcium channel blockers. Actions on the heart and uses in ischemic heart disease. Consultant 1984,24(Dec):150-159.* ***3.*** *Johnston DL, Lesowoy R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985,55:680-687.* ***4.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***5.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease. When to use which. Mod Med 1982;50(Sept):94-116.*

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Would you want your child to become a physician?

By Robert J. White, MD

Our medical schools are quiet now. Their faculties have returned to their laboratories or are vacationing. The students, miraculously transformed through graduation into physicians, have departed to begin their medical careers.

Ah, but wait. Things are far from serene in medical academia, for, while there was a time when any American family took great pride in the fact that a son or daughter had entered medical school, it now appears that all that is changing.

Even the physicians themselves are asking whether they would recommend to their own progeny that they become physicians.

What has happened? What has gone wrong with what many believe to be the most fulfilling and honored of professions? Hardly a day goes by without an article in a newspaper or magazine that describes the changing and declining status of the physician and sets forth the drastic changes taking place in our health-care delivery system, which portend a less-than-ideal job description for the modern-day or future doctor.

Here is a list of some of these particulars:

- The American Medical Association said we have too many practicing physicians, particularly in certain specialties.
- Individual physician incomes are down, and this trend is said to be continuing.
- Recent polls indicate that, while the physician is still the most honored of professionals, as compared to law, government or business, there is no question that the public love affair with the medical doctor has been seriously eroded. He or she is often perceived as insensitive, overbearing and rich.
- Even physicians themselves are criticizing each other. On occasion, they describe one another, particularly those who sub-specialize, as biotechnocrats and lacking in a holistic and humanistic approach in the care of their patients.
- Studies have indicated that the independence and individuality that physicians have enjoyed are rapidly being dissipated, as the contemporary dimensions for health-care delivery are being reorganized into such institutional plans as HMOs, etc., where a physician is really an employee, not an entrepreneur.

Are we slowly but inevitably drifting toward a Soviet-type system of health care, where all physicians are employees of the government and the patient, no longer enjoying the unique relationship with a single physician, must seek medical care through a polyclinic?

Since these possibilities are ever present, the need of the medical profession for the brightest and the best of our college graduates grows even more important now to reverse or modify these trends. Certainly, the format of health-care delivery is changing and

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perhaps needs to be changed; but it will always require men and women who are stimulated by the unique intellectual challenge of patient care and, at the same time, are moved with the satisfaction of being able to relieve pain and suffering.

Medical careers in the '80s, '90s and beyond will remain as exciting and fulfilling as they were before, primarily because the modern-day doctor can cure many maladies and, in other cases, significantly extend life in a quality sense; whereas, just a few decades ago, many of these same diseases were incurable and little or nothing could be done for patients suffering from them.

Forget the economics. Forget the sociology. A medical career will always offer the ultimate in human satisfaction by combining the scientific with the ministry.

Robert J. White, MD, is a professor of surgery at Case Western Reserve University and director of neurosurgery at Cleveland Metropolitan General Hospital. Reprinted with the permission of the Cleveland *Plain Dealer.*

New tobacco warnings

Beginning February 27, 1987, all smokeless tobacco products and ads were required by the Federal Trade Commission to carry health warnings.

The three warnings, which must be displayed in a "conspicuous and prominent place" on the products, include: "Warning: This product may cause oral cancer"; "Warning: This product may cause gum disease"; and "Warning: This product is not a safe alternative to cigarettes."

It has been illegal to advertise smokeless tobacco on the airwaves since August 1986, although smokeless tobacco ads are still being advertised (like cigarettes) in various magazines and newspapers.

Cigarette packages have been carrying warning labels since 1965, and cigarette advertising has been banned on radio and TV since 1971.

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OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians.

Blue collar fitness

"Wellness today is what we call a 'Yuppie' phenomenon," according to Assistant Director for Occupational Health and Safety, Charles Althafer.

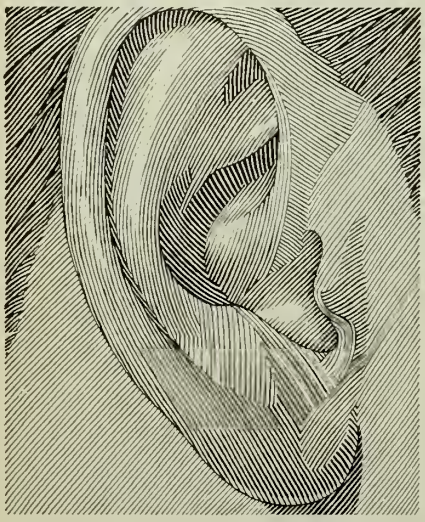
The advent of aerobics, nautilus and racquetball "is a case of the fit getting fitter," he explained in a *Medical Benefits* article. Blue collar workers, for the most part, are noticeably absent from the spa, company gym, weight loss programs, and smoking cessation clinics, he added.

Blue collar employees may fear that management will use the results of health screening programs against them; i.e., if news of their high blood pressure "condition leaks out, they can kiss their careers goodbye," the article stated. Consequently, many of these workers steer away from health programs, which may explain why hourly blue collar workers have a tendency to be at greater risk of heart disease and other illnesses.



Health programs might be more attractive to hourly workers if they are more involved in planning and designing them, and if they feel confident that results of health screenings won't be used against them, the article suggested.

But unless some companies improve life on the assembly line or in the data processing pool, even the best fitness programs won't win the workers' credibility or support, the article concluded.



A crease in the earlobe-heart link

For some time, researchers have suggested that an "earlobe crease" might be a marker for coronary artery disease, but a University of Massachusetts Medical School study disputes these findings.

The earlobe-heart correlation may have been reached "due to the fact that the prevalence of earlobe crease and coronary artery disease each increases with age," the report stated.

The researchers observed 261 men with some degree of coronary heart disease and found equal percentages of those with and without earlobe creases.

Edited by Deborah Athy

Garlic's new allure?

Over the years, garlic has acquired a notorious reputation for lingering on the breath long after the dishes of spaghetti and lasagna have been cleared away. In fact, so strong is garlic's aroma that it has been depicted in literature and in Hollywood as one way to get even with vampires — by placing a wreath of garlic bulbs on the front door of your abode.

But for all the bad press this little spice has reaped, it is gathering impressive laurels in some circles. A growing number of Americans, including some in the health professions, are looking to garlic for its medicinal qualities (not a completely new idea, considering that Hippocrates also sang garlic's praises).

According to a recent American Heart Association (AHA) report, a group of international scientists has synthesized an anti-clotting compound from garlic which may aid those individuals at risk for heart attacks, strokes and hardening of the arteries. And other studies suggest this pungent herb reduces the growth of bladder cancer in mice and may lower cholesterol.

Not surprisingly then, garlic supplements have been joining the likes of fish oil, calcium and fiber supplements on some health food store shelves. However, one of the AHA researchers pointed out that the anti-clotting compound "is completely absent from 'garlic pearls'.

A spokesperson for the Food and Drug Administration Center for Food Safety recently summed up the garlic quandary — at least for the time being — in this way: "Garlic is garlic as far as we're concerned . . . you use it in spaghetti sauce."

Medical enrollment declines

Medical school applications for the 1985-86 academic year fell for the fifth straight year, and, for the first time, more than half of all applicants were admitted, reports an article in *Medical World News.*

Medical colleges received approximately 3,000 fewer applications in 1986, representing a 4.8% decrease from the previous academic year and a 26.5% drop from peak year 1974.

"The decrease is consistent with a growing consensus that the nation's future need for physicians has been met," explains a spokesperson for the Association of American Medical Colleges.

Of interest is the fact that the number of women enrolling and graduating from medical schools continues to increase. Women now account for 32% of the medical school population.

The number of minority students has remained relatively unchanged, while foreign student enrollments have increased by approximately 2.7% since last year.



Smoking and driving

Smokers have nearly 50% more auto accidents than non-smokers, according to a study published in the *New York Journal of Medicine.*

The study surveyed nearly 4,000 drivers who had been involved in driving mishaps. Smokers were found to be involved in 46% more traffic violations than non-smokers, including speeding, running red lights, and other moving violations.

In addition, the study reported that smokers were twice as likely to use drugs and three times as likely to be picked up for drinking and driving.

These results confirmed the researchers' hypothesis that smokers have a tendency to take more risks than non-smokers — whether it's with their lungs or behind the wheel of an automobile.

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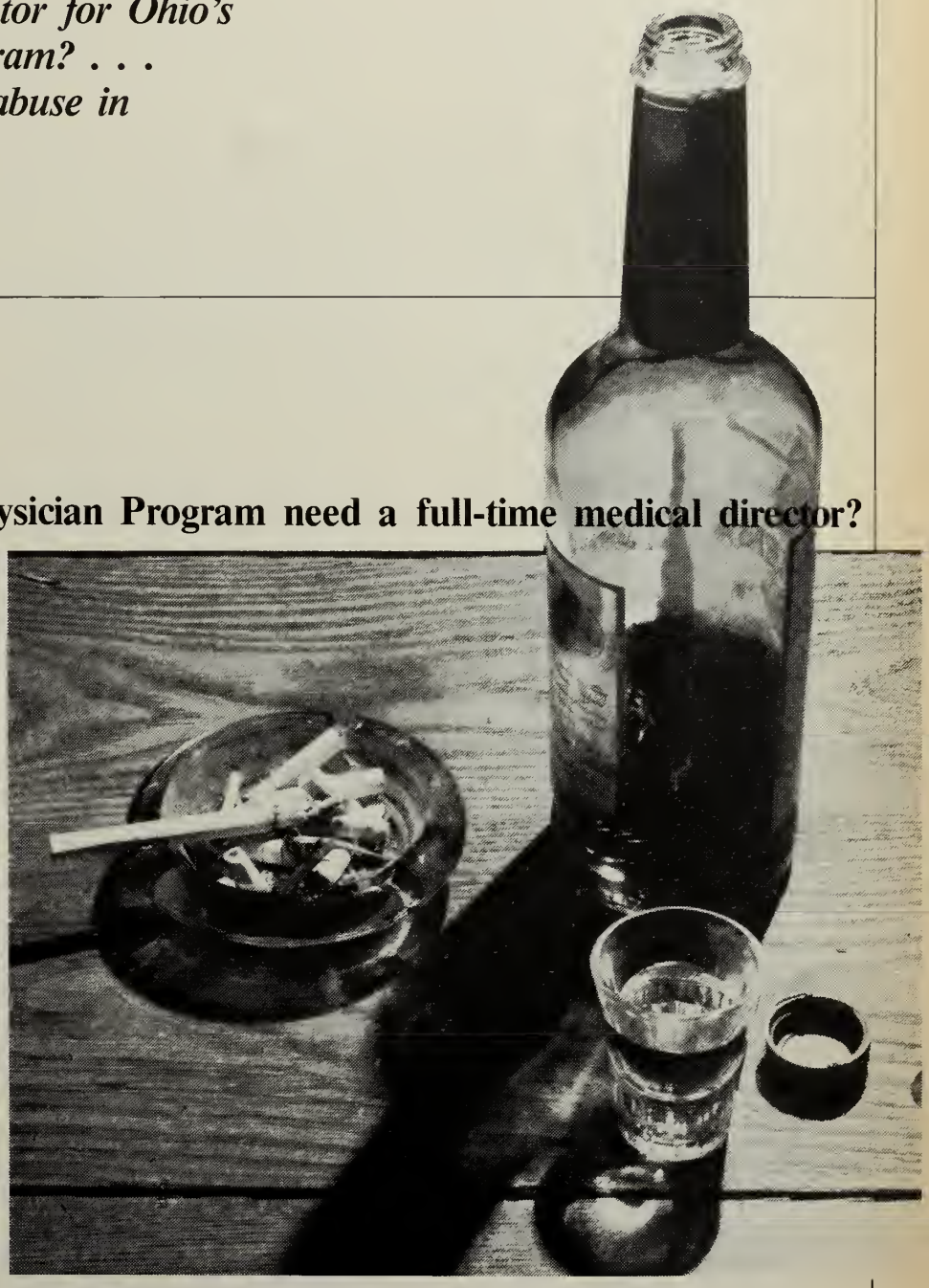
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AIR FORCE



OHIO MEDI-SCENE

A full-time medical director for Ohio's Impaired Physician Program? . . . how to recognize sexual abuse in children . . .



Does Ohio's Impaired Physician Program need a full-time medical director?

Should Ohio have a full-time medical director for its impaired physician program?

That was the question asked in Columbus this past spring at a special conference, "The Politics of Impairment," sponsored by the Ohio State Medical Association.

The impetus for the program began last May when, at the OSMA's Annual Meeting, the House of Delegates voted to refer a resolution that would have set aside a minimum annual budget of $250,000 for a full-time medical director and staff for its impaired physician program to OSMA Council. To date, Council has made no decision on the matter, but continues to seek additional information on the subject.

Toward that goal, then, "The Politics of Impairment" brought in for the day a contingent of experts from New Jersey, where a similar position has already been established.

In explaining the need for a full-time director, Ransome R. Williams, MD, chairman of the OSMA's Committee on Impaired Physicians and Physician's Effectiveness Program, says:

"Our outreach program is limited. We have one OSMA staff person and 30 volunteers, all of whom are busy physicians with their own practices. Yet they do interventions, serve as mentors for those in the program, and as physician advocates. As a result, they burnout early, and ask to be relieved from the committee."

Despite the shrinking number of volunteers, however, the problem of professional impairment continues to increase.

"A significant percentage of the physician population is becoming chemically involved," comments

OHIO MEDI-SCENE

Does Ohio's Impaired Physician Program need a full-time director . . . *continued*

Edward T. Carden, MD, vice-chairman of the OSMA Impaired Physicians Committee.

According to the American Medical Association, that "significant percentage" amounts to one in 10 physicians — with alcoholism acknowledged as the largest problem of impairment. In fact, the AMA projects that somewhere between seven and eight percent of all physicians are either alcoholics already or will become so. To further define the problem, an article on "The Impaired Physician," published in Harding Hospital's publication, *The Bridge,* took the AMA's conservative estimate of seven percent alcoholic physicians and applied it to Ohio's 20,000 physicians. ". . . That means that 1,400 of our Ohio colleagues have or will have alcoholism," the article states.

But does that necessarily imply that a full-time medical director is needed to serve as a "leader" of an impaired professional program?

The AMA projects that between 7 and 8% of all physicians are alcoholics, or will become so.

Vincent A. Maressa, executive director of the Medical Society of New Jersey, believes it does — and he speaks from experience.

"My staff people at the association told me that they couldn't keep up with the program — they were getting calls day and night," he says.

And while volunteers could make the time to intervene and see to it that the impaired professional got care — it was difficult for them to provide any follow-up activity.

Maressa says the volunteers and staff had reached the ultimate frustration level, and the idea of a full-time medical director was proposed. "We made a commitment to do it," says Maressa — "but we wanted to do it correctly."

And *that* meant having adequate funding. In order to acquire the amount of money necessary, the medical association sought out the two medical malpractice insurance companies in the state and made them an offer. If the association would put up a share of the funding, would the two companies make up the rest of the amount needed? They would, and did, and this year, each put in $85,000 toward the program's operating budget.

"Our competitor is an equal participant in an area in which we agree," explains Peter Sweetland, president of the Medical Inter Insurance Exchange of New Jersey.

He insists, however, that his company's participation is not simply a means of keeping up with the competition, nor is it a marketing ploy. "We believe," he says, "that there is potential benefit in investing in a physician impairment program."

"There is plenty of preventable loss around," Sweetland continues — pointing out that that is why the New Jersey program is so rewarding. "They are doing something about it — not just paying lip service to it."

In fact, if the company saves just one suit as a result of the program, Sweetland considers it money well-spent.

"Like it or not, we insurance companies are mandatory players in the problem of impaired physicians."

If insurance companies are mandatory players, then so, too, are the physicians themselves.

David I. Canavan, MD, is a perfect example. As a family physician and the director of a chemical dependency unit at a local hospital, he has been emeshed in impairment problems for years, and had been actively serving on the search committee for a full-time medical director for New Jersey's program, when he was approached to take on the position himself.

Although both Florida and Georgia have medical directors in charge of similar programs, Dr. Canavan became the first to hold the position on a full-time basis. He says he has never regretted his decision to take the job, and believes that more full-time effort is needed.

"Impaired physicians committees are usually composed of volunteer doctors — primarily those who are recovering from their own impairment," says Dr. Canavan. As well-intentioned as these physicians may be, "they operate out of their back pocket, having to squeeze in time between their family and their practice. But you just can't do it that way," he

stresses. "The program needs a full-time effort."

He recognizes, however, that there *are* problems to surmount.

For example, coming onto a staff composed entirely of "career lay persons" created some uncomfortable feelings at first — on both sides. "We recognized the situation upfront, and I assured those on the staff that I would not become involved in any of the administrative duties of the association. So far, I have managed to stay apolitical," he says.

Another problem, of course, was the funding for expenses, salaries and so on. As has already been discussed, the insurance companies, as well as the association, took the lion's share of the financial responsibility — but the group also turned to other service organizations — the osteopaths, the dentists, the veterinarians — in an exchange agreement. They would care for their members in exchange for a share of the bill. So far, that has worked out well, and Dr. Canavan says that a Board of Directors, made up of representatives from all the funding groups, does have final approval over the program's budget. It meets once a year to review the program's expenditures, and approves the following year's budget — "but its members have no idea who is in the program — nor does it (the board) attempt to structure any policy," he adds.

Of course, one advantage of having an impairment program staffed by a full-time professional is that the program can be expanded (as has New Jersey's) to address *all* impairments — not just chemical ones. While the incidence of non-chemical impairment — such as senility and mental illness — is not as prevalent as chemical impairment, those afflicted with such problems are often ignored or overlooked in most impairment programs.

A second advantage of a full-time medical director, says Dr. Canavan, is the fact that he or she becomes recognized — and trusted — by those who sit on the state medical boards.

Michael Grossman, DO, secretary of the New Jersey State Board of Medical Examiners, reiterates Dr. Canavan's thoughts on the matter.

"The Board has confidence in the professionalism of the program," he says, adding that there is a definite advantage to working with the same person. "We don't need to continuously negotiate with new people."

On his side, Dr. Canavan admits that it is easier for one person to learn all the special nuances of the Board.

"The longer I am in the job, the easier it is to open doors and get people back in. That comes from the track record of a successful program. I've also learned what the board wants and what they expect. I don't go in with a case unless I'm sure they'll accept it," he says. "But don't get me wrong. It's still hard to get people back in."

Of course the obvious advantage of a professionally operated impairment program is that it is *not* associated with a state board, and therefore attracts those individuals who might otherwise stay away from more punitive-based programs, points out Dr. Grossman. Yet, *not* being affiliated with a state board also presents some misgivings, he adds.

"We have no control over those individuals we don't see, and that gives us reason for concern," he says. "We suspect there is more (impairment) going on — but," he adds, "we're not sure we *want* to know."

As time goes on, the relationship between the committee and the board has required some careful negotiations as other misgivings and disagreements have come up.

"The first six months, a honeymoon existed between the committee and the board," says Dr. Grossman. "The next six months we began to negotiate."

By that time, says Dr. Grossman, the Board recognized the committee's role as a physician advocate; so, in order to be fair, "we temper our enthusiasm. We are, after all, advocates of the public."

"Impaired physicians committees are usually composed of volunteer doctors (who have) to squeeze in time (for the program) between their family and their practice . . ."

Dr. Grossman explains the basic agreement that has been reached between the board and the impaired physicians committee over time. "If you get to the guy first, he's yours, but if you can't do anything with him, he's ours. And, of course, the advantage of working with paid professionals is that we can tell them if we don't like something they're doing," Dr. Grossman comments.

Whether or not the same board-committee relationship would exist here in Ohio is one of those matters still open for questions.

In attendance at the "Politics of Impairment," however, were several members of the Ohio State Medical Board — as well as representatives from insurance companies, OSMA Council, medical students and county impaired physicians programs. It seems obvious from the number and diversity of those in attendance that interest in a full-time medical director is out there. And Dr. Carden believes the money to fund a program is out there as well.

"The question is," he asks, do the people with the money have the vision to believe that *this* is the place to put it?" — *Karen S. Edwards*

OHIO MEDI-SCENE

How to recognize sexual abuse in children

While society has gradually become more aware of occurrences of sexual and physical abuse against children, the reality of the problem remains difficult to accept.

"There are so many ways to rationalize that this (abuse) didn't happen. You want to believe that these kinds of things don't take place," says Vicki Whitacre, MD, an emergency room physician at Zanesville's Bethesda Hospital.

Unfortunately, these things do take place.

The increasing number of split families — for example, a single mother living with a boyfriend — has been cited as a contributary factor in the growing reports of sexually abused children. Although, as Dr. Whitacre points out, there are some areas which have high percentages of molestation because family incest has been a cultural tradition. "Some families still think it's OK to teach the little girls what will happen when they are older, and thus grandfather, uncle or father initiates the female children."

In the past, there was little encouragement for these kinds of incidents to be reported, Dr. Whitacre continues. But because of increased education in schools and a growing awareness in society, children are now more likely to tell adults, parents, teachers or friends. Consequently, "people are reporting sexual abuse more often."

If the situation is *not* reported, however, should you, as a physician, be expected to recognize the signs? Ideally, says Dr.



Whitacre, physicians should be able to recognize the symptoms of child abuse just as they recognize the symptoms of any other condition.

However, because sexually abused children show up infrequently in doctors' offices, it *is* possible for physicians to miss these signs, she admits. For one thing, many physicians do not examine the genital area as a regular part of a child's physical examination, she says — a practice she believes should be done regularly to uncover signs of abuse as well as other conditions.

Some of the following symptoms and characteristics *may* indicate that a child has been sexually molested, according to Dr. Whitacre. For example:

- The story behind the injury doesn't make sense, especially if the injury involves something like bleeding in the perineum area. "When facts don't fit together, you have to be suspicious," she says.
- Signs of gonorrhea, herpes, chlamydia, or other sexually transmitted diseases. A physician should culture for these diseases if symptoms are present. If a child *does* have a sexually transmitted disease, the chances are reasonable that he or she has been abused, she says.
- Tears in the hymen or vaginal lacerations. If actual penetration has occurred, surgery may be required, Dr. Whitacre points out. Intercourse that causes lacerations is life-threatening to the child, she adds.
- A doughnut ring of bruises around the rectum and/or rectal tears which may indicate rectal intercourse. "You should be suspicious if these symptoms are present," she cautions.
- Any strange interaction between child and parent (or guardian), particularly if the parent is overly protective and won't leave the room or leave the child alone with you. "Sometimes you need to get the child away from the parent and see if the child will explain what happened," suggests Dr. Whitacre.

Training doctors to recognize child sexual abuse

Would you recognize a case of child sexual abuse if you saw one? Probably not, says Charles Felzen Johnson, MD, Director of the Children's Hospital Child Abuse Program in Columbus. According to several studies he has done (and recently published in the American Journal of Diseases of Children), most physicians cannot recognize the physical signs of sexual abuse in children, and, as a result, "they may be indirectly responsible for returning a child to a harmful environment," he says.

As a member of the OSU medical school faculty, Dr. Johnson is aware of the fact that physicians receive little or no training in the area of recognizing child sexual abuse, and so he has developed seminars, as well as teaching kits, which are especially designed to improve physician skills in this area.

"Child sex abuse is like an epidemic," says Dr. Johnson, who adds that seminar participants are frequently surprised at the number of abuse victims his studies and other studies have revealed.

"The average pediatrician will have probably 30 abused children in the practice," he says, but, of course, many are not recognized as victims.

"Recognizing victims requires a certain sensitivity," he continues — not only to the fact that abuse can occur, and occur frequently ("some physicians deny this kind of thing goes on"), but also to the physical and emotional symptoms which indicate a child is being sexually abused. (See related story for a list of those signals).

The physician, too, needs to listen to the child, says Dr. Johnson.

"I believe children when they tell me they've been abused. They don't lie about something like this — especially when they don't understand what the consequences are." Because a case of alleged abuse often comes down to the child's word against the adult's, it's important for the child to know that someone is on his or her side — and it's important for the physician to look for, and be able to recognize signs of abuse to substantiate any accusations which are made.

Also, as the public becomes more informed on the issue of child sexual abuse, more physicians may be faced with a parent who wants their child checked for signs of abuse — based either on the parent's own suspicions or statements made by the child. Here again, he stresses, it's important that the physician know what to do.

"Physicians aren't comfortable diagnosing something they are not familiar with," says Dr. Johnson — and his studies have revealed that few physicians are familiar with children's genitalia. They don't know what the normal size, color and so on should be, he asserts.

"The problem stems from the fact that physicians are not trained how to make examining genitalia part of the child's physical exam. Yet, the genitalia are part of the body and should be routinely examined during every physical check-up," he says.

He admits that parents may be uncomfortable with a physician who conducts such examinations — "but that's part of the training that needs to be done. Parents need to be educated too."

In fact, it is usually the "prudish parents," he says, who need counseling the most. "Many of them don't even teach the child the proper name for body parts."

Although Dr. Johnson has been disappointed, to date, at the physician turnout for the seminars he gives frequently all over the state, he understands that his colleagues are naturally busy and have to be selective about the courses they choose to attend.

And, he adds, the problem is one that is hardly unique to the medical profession. Other disciplines, too, fail to set aside enough time — either before or after training — to teach the fine

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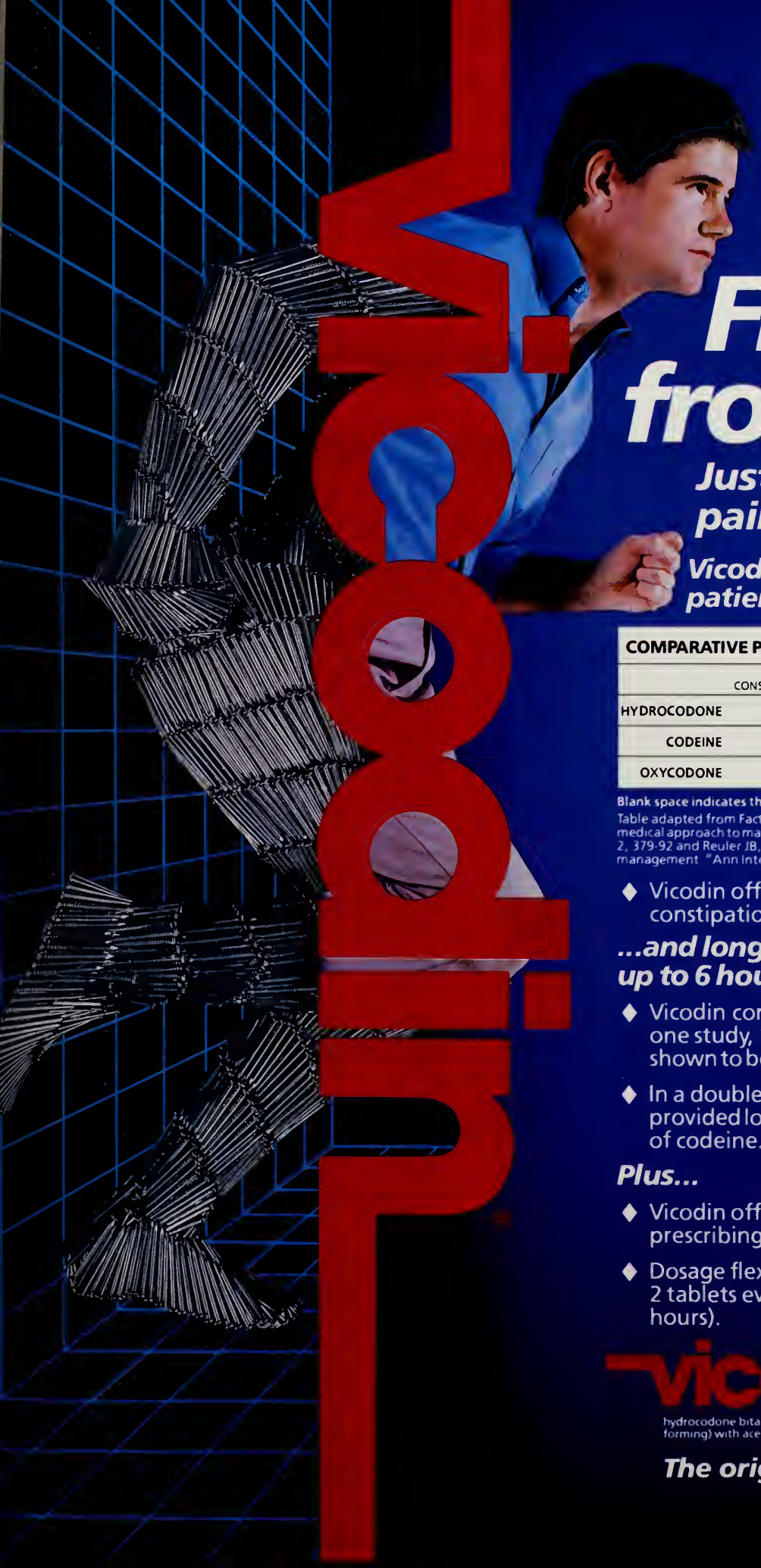
How to recognize sexual abuse in children . . . *continued*

• The child resists examination of his or her genital area. "Most children will give you no problems; they have no obvious fear or objection."
• Other signs of physical abuse — cigarette burns, broken bones, immersion burns (from holding a child under water) indicate there's a chance the child is also being sexually molested. While this isn't necessarily true, Dr. Whitacre says, "If the guardian is doing these other kinds of things, the physician should check the genital area."
• The child turns to the doctor or nurse for comfort, rather than the parent. Dr. Whitacre cites one case in which a live-in boyfriend was molesting a woman's daughter. When the case went to court, the mother sided with the man. The child didn't want to go back to her mother; she wanted to stay with the caseworker.
• Vaginal and urinary infections and/or hurting and itching in the genital area. While there are often other reasons for these conditions, regular recurrences may indicate the child is being abused, Dr. Whitacre suggests.
• If the child tells you there has been abuse. "Kids have been known to tell you what they think you want to hear," she admits. "But 99% of the time when a child says, 'he hurt me down there,' it's true. Children will basically tell you the truth," she says. However, many times the child will be afraid to say anything. "Children are usually instructed or threatened by the person, and told 'this is our secret.' " Unfortunately, the child is usually abused by someone they know and trust, she adds.

"It's beyond my ability to conceive that these things happen," Dr. Whitacre concludes. But when these symptoms do show up in the doctor's office, physicians should recognize the possibility of molestation, keep good records, and notify children services when warranted. — *Deborah Athy*

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CLASSIFICATION: Legend
APPROVAL DATE: March 19, 1987
NDA #: 19-655
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CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov) 1984 and Catalano RB The medical approach to management of pain caused by cancer "Semin Oncol" 1975, 2, 379-92 and Reuler JB, et al The chronic pain syndrome misconceptions and management "Ann Intern Med" 1980, 93, 588-96

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Revised, April 1982. S685

1. Hopkinson JH III *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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How to recognize child sexual abuse . . . *continued*

points of recognizing child sexual abuse. "The College of Social Work, for example, has no formal instructions in this area," Dr. Johnson points out.

But that may soon change. Dr. Johnson has recently received a grant to explore the feasibility of establishing an in-depth multi-disciplinary program at OSU in which participants would be trained to recognize and work with victims of child abuse.

"The program would include those involved in law, medicine, nursing, psychology and social work," says Dr. Johnson, who will be working on the project over its three-year period.

He will, however, continue to present his seminars around the state "to anyone who will listen" (although, of course, laymen receive a more generalized, less graphic seminar than his physician-audiences). His next seminar is scheduled for August 15 in Columbus. Anyone wishing further information on this seminar (or others), or who might want to order one of the teaching kits which comes complete with pre and post test forms, should contact Jean Schafer, Children's Protective Services, Ohio Department of Human Services, 30 E. Broad Street, 30th Floor, Columbus, Ohio 43266-0423, 466-2989. — *Karen S. Edwards*

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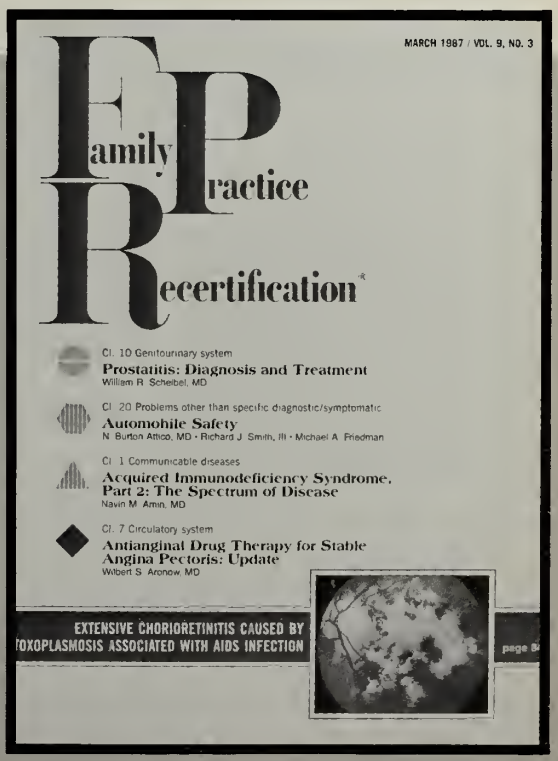
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How to Keep Yourself Out of the Courtroom

By Karen S. Edwards

As malpractice continues its stranglehold grip on medicine, physicians are naturally looking for ways to sidestep its far-reaching grasp. As a result, they are ordering more tests . . . drawing up informed consent forms (so patients can never claim, "I wasn't told") . . . and documenting everything they do on the patient's medical chart. The name of the game is "How to Keep Out of Court," and most physicians, these days, are playing it with a vengeance. But what they — and you — may not realize, is that many of these actions may be doing more harm than good.

"Malpractice has nothing to do with the standard of care a physician delivers," says Thomas A. Gutheil, MD, who, in addition to serving as director of the Program in Psychiatry and the Law at the Massachusetts Mental Health Center, is regularly called on as an "expert witness" in well over 20 states, including Ohio. Dr. Gutheil was recently in Columbus to speak at a one-day symposium on liability issues sponsored by Harding Hospital.

"You know and I know," he continues, "that there are good cases that get litigated, and bad ones that don't."

Of course, in order for *any* malpractice suit to stand a chance of coming to trial, it must contain certain elements — what Dr. Gutheil alliteratively refers to as the "four Ds of malpractice" — "the Dereliction of a Duty Directly causing Damages." In other words, there must be: 1) provable negligence; 2) a definite physician-patient relationship; 3) proximate cause; and 4) a bad outcome of some type — either injury or death. Yet, even with all of these elements present, there is no guarantee that the case will ever come to trial.

What *will* trigger that initial phone call to an attorney, says Dr. Gutheil, is the coupling of a bad outcome with bad feelings — an explosive combination, which he says accounts for most of the malpractice suits currently in litigation.

"Guilt, rage, grief and surprise are what will bring a case to trial," he says.

He recommends that physicians take extra time to talk to patients — to tell them what to expect from a medication or an operation, so that they aren't surprised at the slight tingling sensation in their fingers, for example, or the "cotton mouth"

"Most consent forms require the same reading level needed to read* Scientific American *— and that's a very technical, sophisticated journal."

they will experience upon waking from surgery.

"If patients know to expect these things, they'll relax and not worry about them," says Dr. Gutheil — but what they *don't* know may hurt *you* in the long run.

In a sense, this ongoing dialogue between you and your patient is the epitome of "informed consent" — often better, says Dr. Gutheil, than those complicated consent forms drawn up by attorneys.

"Those forms have been designed to protect — not inform," says Dr. Gutheil, pointing out that they are usually written in "boilerplate" language — where the word "give" often becomes the more ponderous "convey."

"Most consent forms require the same reading level needed to read *Scientific American* — and that's a very technical, very sophisticated journal," he claims.

Besides creating general patient confusion, consent forms are not exactly "jury-pleasers" either.

"All you have to do is read one of those consent forms to a jury," Dr. Gutheil says, "and you've made your point that the patient could not possibly have understood the risks — because no one on the jury can understand it either."

So, what *can* you do to keep the patient informed, and, at the same time, convince a jury that the patient knew — and *understood* — the risks and benefits of a given treatment?

"Use a standard spiel when you talk to the patient," suggests Dr. Gutheil, who adds that developing a sort of verbal patter accomplishes two things. First, it opens up a dialogue between you and your patient, and second, juries are very comfortable with it.

"All you need to do when you're asked about whether or not you provided informed consent is to say you delivered your standard spiel of the risks and benefits, and it goes something like this . . . then, you go into it for the jury," Dr. Gutheil says.

If you documented that you delivered your speech, the burden of proof now shifts to the patient.

"He or she must prove that you *didn't* do it."

He also recommends that you write down any questions the patient might have asked either during or after your spiel, or at least note the fact that questions were asked.

"It shows that the patient was participating in the discussion," he explains.

On the matter of documentation, however, how *much* material you should be putting into your records is still wide open for discussion.

While Dr. Gutheil believes that physicians should take care to document their decisions — "lawyers think that if you didn't write it down, it didn't happen" — he disagrees with the amount that is needed.

"Don't write more — write less, but write smarter," he advises.

He urges physicians to phrase their notes carefully — and, above all, to avoid thinking legalistically when writing on the patient's chart.

"This is defensive, cover-your-ass kind of medicine," he notes, adding that such legalistic thinking sets up an *adversarial,* rather than a clinical, relationship with your patients — automatically converting them into the enemy.

"Instead of taking the position, 'what does this patient need?,' what is best for this patient?,' you end up running your practice for the attorney you think is going to step in and scrutinize your notes," he says.

Josiah Blackmore, JD, Dean of the Capital University Law School in Columbus, and another speaker at the Harding symposium, agrees that less can be better — but he cautions against turning your records into "self-centered conservatism."

"You can be *too* adept at reducing your risks," he says, explaining that if you fail to write down the bad, as well as the good that happens in your practice, your notes will appear self-serving — and naturally reduce your credibility in a court of law.

One thing that *should* be in your notes, however, is the fact that you've conducted some "curbside counseling" with a peer.

"The whole premise of malpractice rests on whether or not you are practicing an average level of care. In other words, you are compared to your peer group," says Dr. Gutheil.

Therefore, it stands to reason that — in a sticky situation — you should consult with a member of

your peer group to see whether or not your peer would take the same course of action.

"This doesn't have to be a formal consultation," continues Dr. Gutheil. "A quick phone call to discuss the situation, what you intend to do or prescribe, and whether or not your colleague agrees is all you need. If you don't mention the name of the patient, and you make the details of the case sketchy, you're not going to be placing your colleague at risk," he assures.

But some caveats *are* needed here, as even "curbside counseling" needs a degree of privacy.

"The two places where most major breaches of privacy occur are the hospital cafeteria and the hospital elevator," says Dr. Gutheil. Save your questions for the office, he suggests — and Blackmore recommends physicians think twice before discussing *any* case on a mobile telephone.

"There was a case, recently, where two doctors discussed the care of a patient during one of the doctor's absence. The conversation was conducted over a mobile telephone and the entire discussion was somehow picked up and broadcast over a local radio station," he recalls.

Just as peer opinion should find a place in your records, so, too, should patient interaction, says Dr. Gutheil.

The obvious advantage of relating the risks and benefits of a certain procedure or a particular medication to a patient is to allow him or her the opportunity of sharing in the decision-making process with you. The informed consent — or spiel — and follow-up interaction show that you recognize the patient, not as a helpless child, but as someone who is capable (as long as he or she is competent, of course) of helping to decide what treatment is best.

Admittedly, sometimes the choice will be tragic.

"In cases of schizophrenia, for example, the choice may be between the absence of schizophrenic symptoms, and tardive dyskensia," says Dr. Gutheil.

Still, by involving the patient, determining the patient's preference, and documenting that choice, you may well be able to avoid a malpractice suit.

It goes back to the theory of "bad feelings plus bad outcome equals malpractice," explains Dr. Gutheil. If you make sure that there is no surprise, no guilt or rage present that will later need to be "worked out" in litigation — then there may be no malpractice suit. "Just make the patient your partner," suggests Dr. Gutheil.

Another point to keep in mind, he adds, is to keep the family informed too, since *their* surprise/guilt and/or bad feelings may lead you into problems.

Once you've involved the family — and the patient — in deciding treatment; carefully documented their involvement, and given them your standard patter on the benefits and risks of treatment, are you safe?

Maybe. There are never any guarantees in medicine, of course, but following the above steps will, at least, help increase communication — which, in turn, will help decrease those "bad feelings" that often result in a lawsuit. Of course, if you *really* want to play it safe, Dr. Gutheil has a list he refers to as the "Six C's of Malpractice Prevention" that is worth mentioning:

1) Concentration to task
2) Concern for patient
3) Communication with patient and other treaters
4) Consent (from the patient)
5) Consultation, and
6) Courage in participation.

However, Dr. Gutheil stresses that your behavior toward your patients may ultimately play the greatest role in malpractice prevention. What kind of behavior is best?

First of all, there should be an attitude of respect for the patient, he says — and respect your patients enough to give each one the time he or she needs with you.

"Take on only the number of patients you feel you can reasonably treat," says Dr. Gutheil, "but take care before you 'abandon' a patient."

Anyone can stop seeing a patient at anytime, and for any reason, says Dr. Gutheil — but before *you* do, see to it that there is a continuum of care. "Provide an alternative system of care for the patient, and do not abandon (him or her) if they are in a crisis situation. Take care of the crisis and *then* follow through by finding alternative systems.

"Abandonment sets up such bad feelings," he continues, "that it's important to go the extra mile."

For example, if a patient has not paid your bills, Dr. Gutheil suggests that you make arrangements for a fair payment system; or, if that doesn't work, "get the patient into a free clinic — and then open the door by telling the patient how to come back into your practice," says Dr. Gutheil.

Also, be sure that you have adequate coverage for patients in your absence and maintain a "clinical disinterest" which, of course, must somehow be carefully balanced with a sense of caring and concern.

To put the matter of liability into even sharper focus, Dr. Gutheil lists the common types of malpractice (or lawsuits) filed against physicians, so you can serve as your own "watchdog":

1) Misdiagnosis
2) Negligent use of drugs
3) Respondent superior (over

"Instead of taking the position 'what does this patient need?' . . . you end up running your practice for the attorney you think will scrutinize your notes."

which you have little control, Dr. Gutheil notes, since this refers to the common practice of "firing a suit as high up as you can go, and involving as many people as possible."

4) Abandonment
5) Breach of privacy
6) Defamation
7) Wrongful death
8) Undue influence, and
9) Fraud

"Also, be careful about those cases where you deliver care without actually seeing the patient," warns Dr. Gutheil. He describes that practice as a "litigation time-bomb waiting to go off."

"Attorneys, as a group, haven't discovered it yet — but they will," he says.

Finally, practicing with common sense — and with an eye toward the Six C's of Malpractice Prevention — may be all you can reasonably expect to do to keep communication between yourself and your patient open — and yourself out of the courtroom.

"And when you think about it," concludes Josiah Blackmore, "aren't the Six C's of Malpractice Prevention also the six C's of *any* good medical practice?" **OSMA**

Karen S. Edwards is Executive Editor of **OHIO Medicine.**

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So You're Being Sued for Malpractice . . .

By Susan Porter

Like most surprises, it happens when you least expect it. You're in the midst of a desk full of paperwork or in the middle of examining a patient, when you're told a certified letter has arrived for you. A premonition tells you the news is bad — and you are right. The letter contains a Summons and Complaint. In plain English, you are being sued for malpractice.

If this scenario has never happened to you, fear not — chances are good that sooner or later it will. Nearly half of the physicians responding to an OSMA survey on professional liability last year already have been sued for malpractice at least once. Since 1981, there has been a steady increase in the number of suits filed against Ohio physicians, so that it is relatively safe to say that this year, more Ohio doctors will be served such a Summons and Complaint than ever before.

Hundreds more will be notified in writing that their patients are considering filing a lawsuit against them, according to Martha Althauser, an attorney and assistant vice president for Physicians Insurance Company of Ohio (PICO). This notice of an intent to file automatically extends Ohio's one-year statute of limitations by 180 days, giving the patient an extra six months to take action against you, should he or she so desire, Althauser says. "In about half the cases, the doctor

"There is something about getting out of the medical environment that helps physicians realize that it's the lawyer's ballgame . . ."

receives this notice," she says, although frequently, the patient never follows through with the suit.

No matter which it is — a certified letter containing a Summons and Complaint or a notice of an intent to file action, your initial reaction is likely to be one of shock and disbelief. Whether you are the only defendant being named in the suit or one of several specialists who treated the patient, your first question is likely to be, "Why me?"

The surprise is quickly followed by a "normal bitterness," says James Oliphant, a defense attorney with the Columbus firm of Porter, Wright, Morris and Arthur who frequently defends doctors in malpractice cases. "The doctor may have gotten up in the middle of the night to take care of this patient," says Oliphant. "Or he may have saved the patient's life. And what did he get in return? A lawsuit."

Later, feelings of self-doubt, anxiety, depression and disillusionment are likely to take over, as you ask yourself what you could have done differently to change the outcome. In short, such a challenge to your professionalism and integrity can be emotionally devastating, and, more than likely, it will change the way you practice medicine forever — if you decide to continue doing so.

Added to this personal trauma is the stress created by the slow and cumbersome legal process itself. It can take months and years before a case is finally settled. "For doctors who have never been to court, it's a brand new process," Althauser says. "Many are unnerved by the whole thing."

Physicians, especially, are used to making their own decisions in a quick and efficient manner, and getting almost immediate results. But the wheels of justice spin slowly, and doctors are forced to take a back seat in the decision-making process — to rely on the judgment of their legal advisers.

"Anytime you go into an area outside of your expertise and have to rely on other people's judgment, this can be very difficult," says Althauser.

Yet the worst thing a defendant can do, says Oliphant, is to question or try to override the attorney's advice. In private consultations, this can create difficulties, but in testimony and hearings it is devastating if the physician and his or her attorney openly disagree.

Thus, Oliphant insists that "the lawyer has to take and keep control" from the onset of the case. This is one reason he insists meetings be held in his office — not in the physician's office. "There is something about getting out of the medical environment — getting into a car and driving to the law office — that helps physicians realize that it's the lawyer's ballgame, that helps them to accept the lawyer as the expert," he says.

Regardless of your initial emotional reactions to the news you are being sued, the first step you should take is to call your professional liability company, says Althauser. Your insurance company will assign your case to a law firm that has been fully investigated and approved by its board of directors for its ability to defend you in such a case, she says. If you have no insurance, or the amount they seek far exceeds the limits of your policy, you may want to hire your own attorney as well.

Explanations not in order

What you should never do, however, is to call the patient or the patient's attorney and try to explain your side of the story — or to talk them out of the case. Even if you have had a bad result and suspect a patient may want to sue you, "don't try to get around it by buddying up to the patient and hoping he'll forget it," suggests Gerald Todaro, a lawyer who most frequently takes the plaintiff's side in such cases, although he has, on occasion, defended doctors, as well. Todaro, who teaches a mini-course at the Ohio State University School of Medicine on the medical/legal problems facing practitioners, says that while maintaining constant communications with all of your patients is an important part of preventing such suits, "if you start showing up on their doorsteps, they're going to get suspicious."

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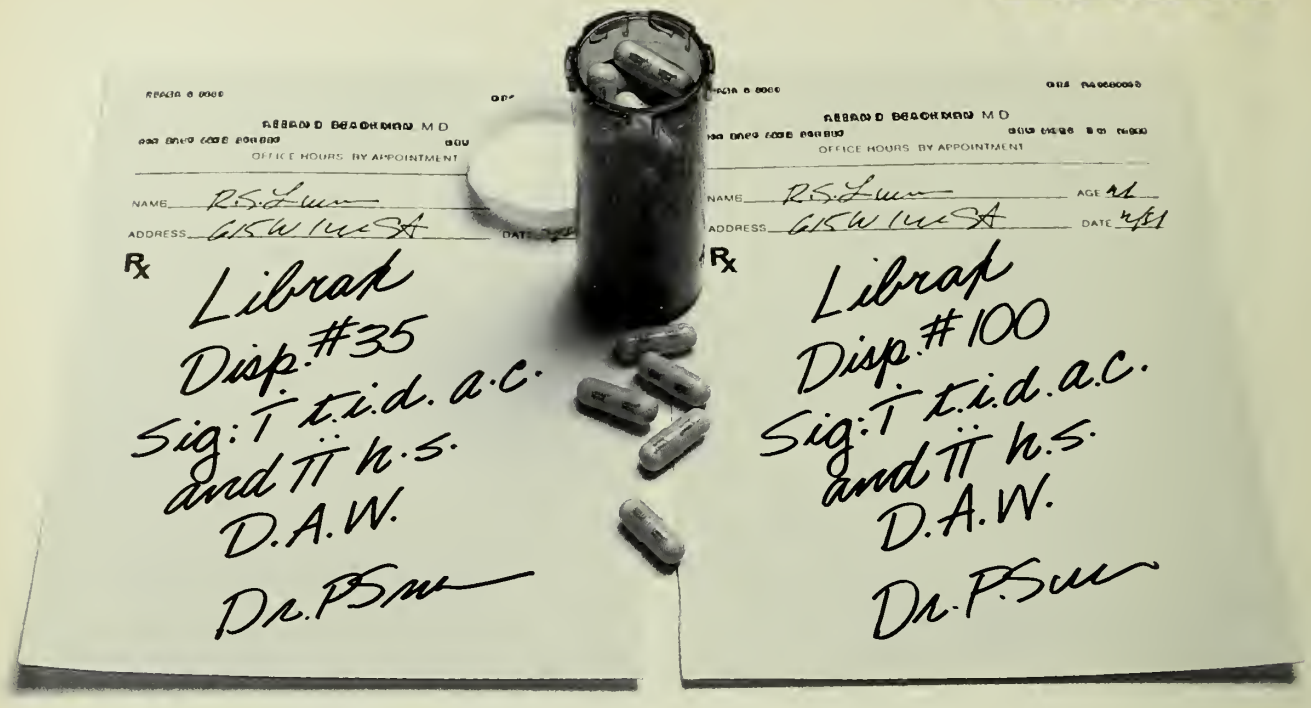
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"Most physicians don't have a good understanding of what's involved. They think that only medical issues are involved. They have no idea of the legal issues . . ."

opportunities to present your side of the story as the legal process proceeds, says Althauser. The first chance is when you and your attorney sit down and answer the Complaint section attached to your Summons, which is simply a list of the reasons why the plaintiff is taking action against you. "Each paragraph in the complaint will be answered separately, on a point-for-point basis," Althauser explains. Answers generally consist of a simple acknowledgment or denial.

"For example, if there is a corporation identified, you will admit that you are a part of that corporation and that it is licensed in the state," she explains. Allegations of negligence or incompetence, on the other hand, are usually answered with a general denial.

As with all civil cases, the defendant has 28 days to answer the complaints filed against him or her. A failure to do so — or to follow through with other steps required in the legal process — is tantamount to admitting guilt, although extensions to deadlines can be obtained if there is good reason for doing so.

Once your statement has been filed with the court, a stage called "discovery" begins, says Althauser. During this phase, each side attempts to gather pertinent information in order to build its case. This is accomplished through two methods: interrogatories — or a written list of questions submitted to the other side, which are then answered in writing — and depositions, during which oral questions are presented and answered before a court reporter.

Building a case

In most cases, the interrogatories or written questions are used to gather background information and to obtain appropriate records and documents, says Althauser, in order to save time during the depositions. "The types of questions the doctor is likely to be asked," she says, "are: Is the physician insured? What are the limits of the policy? Where did the physician go to school? When did he/she graduate? On what dates did he/she treat the patient? Did he/she consult with other physicians about the case? What drugs did he/she prescribe? etc." This gives the plaintiff a chance to build a case and to request copies of all records and documents that might be pertinent to the case, Althauser says.

During this phase, however, the physician and his or her attorney also get a chance to submit written questions to the patient who is suing. Some samples of these, according to Althauser, are: What kind of injuries is the patient claiming? What kind of subsequent treatment has he/she had? With whom and on what dates? What actual expenses were incurred? The defense can also ask the plaintiff to identify the expert witness who will be supporting him or her in the case. An expert witness is required in malpractice cases because an ordinary citizen is not qualified to charge that the appropriate medical care was not rendered, Althauser explains.

Again, the state provides 28 days to file these interrogatories, and, in turn, each side has 28 days to respond in writing to the other side's request for information. After this, generally, oral depositions are scheduled, when each side has a chance to call in the other side's key witnesses and ask them questions about the case. These generally take place in the attorney's office before a court recorder, and while they are more open and informal than a trial, the sworn testimony which results is admissible evidence for a subsequent arbitration hearing and trial, should the case reach that point.

Depositions are also a good way to help determine if a case really exists — or if a settlement might be advisable. For all of these reasons, depositions often are critical to the outcome of the case, Oliphant relates. While some doctors "are extremely good in communicating and persuading" the plaintiff's attorney during these long and usually stressful oral interrogations, "others have a very difficult time with it." According to Oliphant, "the best witnesses at depositions are those who speak to the point, very briefly." Doctors get into trouble,

Malpractice Dos and Don'ts

DO call your professional liability insurance company immediately upon notification that a suit may be or is being brought against you.

DO level completely with your defense attorney. The rules of confidentiality protect conversations between you and your lawyer, so, generally speaking, you need not worry that information discussed in private consultations will be used against you.

DO trust your insurance company's selection of a firm to represent you. The activities and records of these law firms have been carefully analyzed by the company, in order to determine the firm's ability to defend doctors in professional liability cases. If you do not like the individual attorney representing you, take the matter up with the head of the firm. If you're still not satisfied, discuss the matter with your insurance company.

DO answer your attorney's questions candidly and honestly. Learn to trust his or her judgment and allow him or her to make relevant decisions. Your attorney has spent much more time in the legal system than you have. There are generally good reasons for the way he or she is handling the case.

DO get involved in your case — by helping your attorney obtain and interpret the proper records, background information and testimony from witnesses on your behalf.

DO plan to take a considerable amount of time away from your practice, especially once the trial has begun.

DO attempt to prepare yourself mentally and emotionally for your depositions, arbitration and trial by reviewing the case thoroughly with your attorney, making yourself familiar with the legal process, practicing responses to questions and learning to cope with stress.

DO attend your attorney's depositions of the patient, the patient's expert witness and others planning to testify against you. It is much more difficult for them to speak out against you when you are sitting in the same room with them.

DO try to stay in top physical and emotional shape. Some attorneys recommend taking up a new sport or exercise, or signing up for stress management classes, in order to help you cope with the long, tension-filled hours you may eventually spend in depositions, arbitration and trial.

DO answer questions as briefly and honestly as possible when you are asked to testify. Don't be afraid to say "I don't know" or "I don't remember" if, in fact, you don't.

DO plan to be present with your family at all times during the trial, if possible. Remember, the patient and his or her family will be there in order to obtain the jury's sympathy. Your absence may be viewed as apathy or a "too busy to be bothered" attitude — even if you have legitimate business to take care of outside the courtroom.

DO practice patience. The legal process, by its very nature, is a long and cumbersome one. It may take months and even years before your case is closed, settled or comes to trial. Anger and frustration only make things more difficult for you, your family and your case. Learn to accept the fact that there are no overnight solutions to your problem.

DO NOT go out and hire your own legal defense — unless you have no professional liability insurance or the amount of the suit far exceeds the amount you are insured. In most cases, your

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however, when they attempt to overexplain, or when they get upset or lose their tempers.

According to Todaro, "If the doctor becomes very emotional or angry during the deposition, it detracts from his or her credibility." Another pitfall physicians fall into, he says, is when they attempt to reconstruct every step involved in the care rendered to the patient, inserting or fabricating what they can't remember or what was left out. "If what they're telling you doesn't show on the chart, it's pretty easy to make the defendant look like a liar," he warns.

Thus, most attorneys will suggest simply sticking with the facts and an honest, "I don't remember" or "I don't know" when such an answer is appropriate. Often the physician will feel frustrated, because it is the patient's lawyer who is controlling the questions, and they don't get a chance to say what they want," Oliphant says. "But I assure them that if the case goes to trial, they will get their chance on the witness stand."

In addition, many physicians have a "very naive sense of justice," says Oliphant. "They believe that if they really tell everything, just the way they see it, they will convince the plaintiff's lawyer and the plaintiff that they are a good person, that they did nothing wrong — and they will drop the suit."

Unfortunately, what happens more often is that the information is taken out of context and used against the physician later in arbitration and trial. This is because "most physicians don't have a good understanding of what's involved. They think that only medical issues are involved. They have no idea of the legal issues. And they tend to think in very simplistic terms — on a black and white, guilty or innocent basis."

But guilt has very little to do with it, says Oliphant, and a lot of gray areas exist where legal issues are concerned. "I try to explain to them that they're not being accused of a crime — that it's not a matter of being guilty or not guilty." Instead, he explains, the plaintiff's attorney must try to prove that the physician departed from a certain accepted standard of care in diagnosing or treating the patient.

According to Althauser, medical texts and journals, medical research, expert witnesses and other specialists may be used by both sides to show that the care rendered was or was not up to a standard accepted by the profession. The physician's own records and documents will be used to see what type of care was given, the factors he or she considered in making key decisions, and whether or not the patient was aware of the risks involved.

"What we try to boil it down to is a matter of medical judgment," says Oliphant, "— and then prove that the doctor exercised his or her best medical judgment under the circumstances." Even if the results were less than was hoped for, as long as the physician followed standard and accepted practices and rendered the best judgment possible under the circumstances, he or she is not guilty of any malpractice.

It is for this reason that most cases never reach the arbitration and trial stage. Once all the facts are out on the table, the issue often is dropped or settled. According to Althauser, 80% of PICO's cases end with no payment made to the plaintiff.

Many physicians find it difficult to settle, says Todaro, because "professionals don't like to admit they may have done something wrong. If they had known it was wrong, of course, they wouldn't have done it; but, in retrospect,

Appeals in Malpractice Cases

I have no figures to support the idea, but my intuition is that malpractice cases get appealed more often than other kinds of cases. In a malpractice case, each side views the other side's position as a personal affront. The loser almost always feels the jury's verdict is not fair and appeals. The winner is frustrated, because the case is not over but drags on through the appeal process. The appeals, however, are not often successful.

Many people, including most physicians, are not familiar with the appeal process, and what it is that an appellate court does. An appeal is not a trial *de novo;* no new evidence is considered. The appeals court does not hear witnesses, and does not decide disputed issues of fact. The appeals court simply reviews the file in the case and decides whether, all things considered, there was a fair trial.

A court of appeals is analogous to the medical peer review committees which review the work of physicians and staff. Like the court, the committee reviews the file, and makes a decision regarding the quality of care.

An appellate court is like a review committee, in that both perform separate but distinct modes of analysis. One is the case-deciding mode, and the other is the rule-making mode. In the case-deciding mode the review is simply limited to considering whether an individual's case was properly handled. There may be minor lapses, misjudgments or errors which do not affect patient outcome. In law we call these minor lapses "harmless error."

The rule-making mode is an entirely different kind of analysis. The emphasis is not on the result in any particular case, but on practice in general. If a review committee finds that a certain course of post operative care leads to less patient discomfort and an earlier discharge, the committee may adopt that course as a standard procedure and recommend it in all cases. In law, this same rule-making process is simply called setting a precedent.

One main difference between medical review and legal review is that a medical review committee cannot change what has happened. The committee is limited to what the patient's file shows, and one cannot go back and change that. A review committee cannot order a new appendectomy. It is usually limited to its rule-making function, i.e. to adopting a policy to prevent this sort of thing in the future.

An appellate court can, of course, order a new trial, but in many respects it is as limited as the medical review committee. What's been done has been done. The jury has found certain facts to be true, and rendered a verdict. There may have been errors in the trial, but every trial has some error; and a new trial may also have error, just as remedial surgery has risks. Where there is some egregious error which probably affected the final outcome, a judgment might be reversed and a new trial ordered.

This does not happen that often. Appellate courts, like peer review committees, usually concentrate on our rule-making function. Most cases are within the accepted standards, most have followed the accepted legal precedents, and in most there is little a court can do to improve on what has been done.

Nonetheless, because the parties to a malpractice case are often so emotionally involved, the appeals, successful or not, continue. — *Lawrence Grey, Judge, Fourth Appellate District, Athens.*

"A jury verdict often depends on the credibility of the witnesses, the sympathy factor, general appearances — even secret vendettas a jury member may have against his or her own physician . . ."

you sometimes have to admit you should have handled things differently."

Oliphant points out that in making a settlement, a doctor signs a paper which releases him or her from any professional liability involved in the case. "It specifically says that this is not an admission of liability — and that liability is expressly denied," he says.

So why settle? "Settlement is merely a compromise of risk," says Oliphant. "There is a certain risk involved in taking a case to trial. If the case is presented to a jury through expert testimony, there is always some degree of chance the case will be found in favor of the plaintiff."

Even when little or no case exists, a physician who insists on seeing a case through is at some risk, says Todaro. "A jury verdict often depends on the credibility of the witnesses, the sympathy factor, general appearances — even secret vendettas a jury member may have against his or her own physician."

In deciding whether or not to take that risk — to proceed or to settle," a physician needs to decide just how many battles he wants to take on in life," says Todaro. "You've got to pick and choose your fights carefully and ask yourself, 'Is this one worth fighting?' "

Again, the physician's attorney and malpractice insurance company are best qualified to decide whether or not a settlement is appropriate, although according to Althauser, PICO will not settle a case without the physician's written consent. Should the case proceed beyond the discovery phase, an arbitration hearing and trial date will be set.

Ohio law requires that all malpractice cases first go to an arbitration hearing, which is a board consisting of three individuals: one designated by the plaintiff, one by the defendant or defendants, and one by the court. The arbitration process operates much like a mini-trial — hearings, usually held in the county courthouse, are public and evidence is presented on both sides of the case.

Arbitration hearings are generally less formal than court hearings and the rules are less restrictive on what can be presented as evidence. The arbitration board not only decides the issue of liability, but it also suggests the amount of damages that should be awarded, should the case be found in favor of the plaintiff.

However, the findings of the arbitration panel are not binding, and if either side disagrees with the results, the case goes on to trial. "This can be either a court trial where a judge hears the evidence or a jury trial," Althauser explains. "Either side can request a jury."

As in any civil case, eight jurors are selected and given specific instructions about the case. "Each side has the right to request certain instructions be given," says Althauser. "You may want to instruct jurors regarding the legal definitions of terms, what is required to establish medical evidence, what burden of proof needs to be established by the plaintiff, etc.," she says.

Of all of the long-and-drawn-out phases involved, the jury trial is generally the most difficult for the physician and his or her family. Not only must the physician plan to take an extended period of time away from his or her office — thus losing his income over that time period — he or she must sit calmly and quietly while his or her professionalism, reputation and integrity are torn apart. "It is very painful to sit and listen to the other lawyer tell the jury how bad you are," says Oliphant.

"Once the jury renders its opinion, each side has the right to appeal," says Althauser. However, the case must be appealed on the basis that the trial was not conducted properly — not on the fact that you disagreed with the outcome of the trial (see related article).

Should you and your attorney decide that the amount the jury awarded the plaintiff was unfair, however, you can ask the judge to reconsider and reduce the amount, says Althauser. "If the judge decides the jury was influenced by passion and prejudice and not by the facts of the case — he or she can change the amount," she says. "However, the judge cannot change or overrule the verdict itself."

If the amount of the award exceeds your insurance coverage, most insurance companies will attempt to settle with the plaintiff for the amount for which you are insured, says Althauser. If,

however, the patient does not agree to a lower award, he or she may begin legal proceedings against your personal and business financial assets.

Needless to say, the financial, emotional, physical and mental strain involved in a malpractice suit is overwhelming and cannot be underestimated. In some states, support groups are being formed by doctors who are going through or have survived the ordeal. Sadly, many doctors who have been sued are troubled for years by the emotional ramifications of the process, and some decide to drop out of practice altogether to avoid another incident.

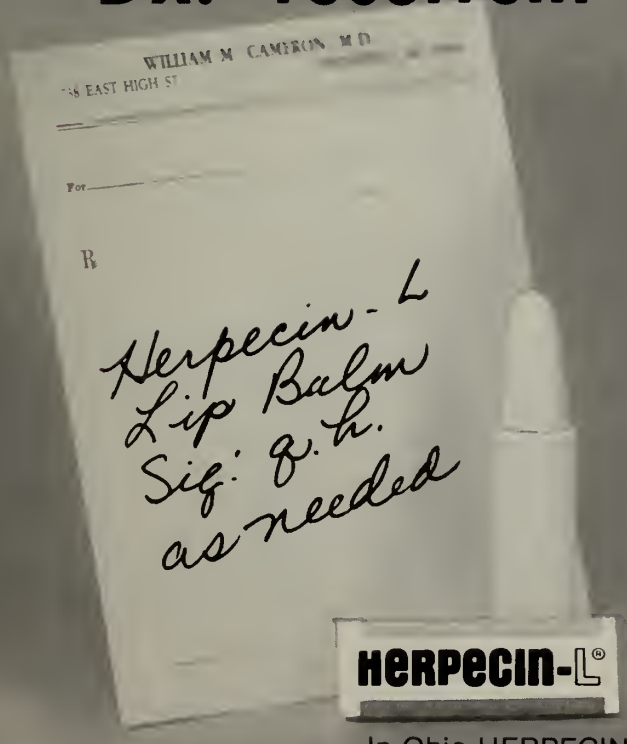
The best way to avoid a malpractice suit is to take every precaution possible, says Althauser: keep thorough records, document all procedures, and continually communicate any and all risks to your patients (see related article). But should you find yourself in such a situation, there is some comfort in knowing that you're not alone — that professional liability is just another ever rising and ever real cost in the business of practicing medicine. **OSMA**

Susan Porter is the Associate Director of the Department of Communications.

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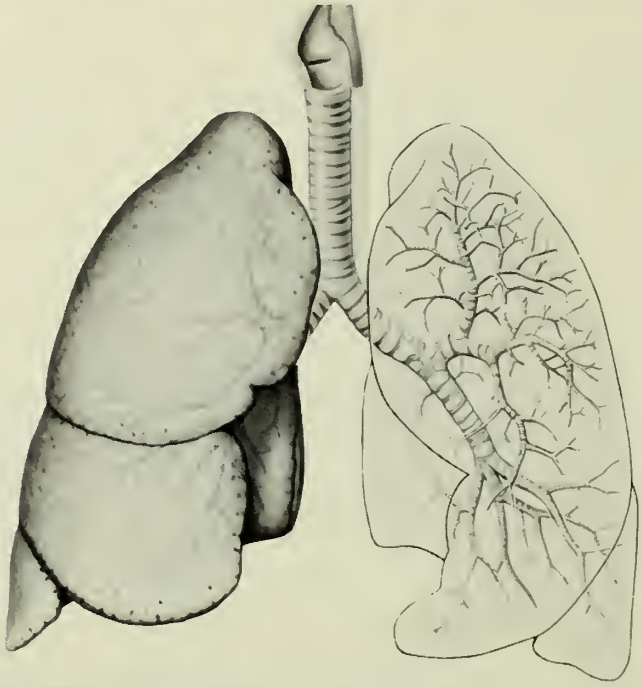
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Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
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- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

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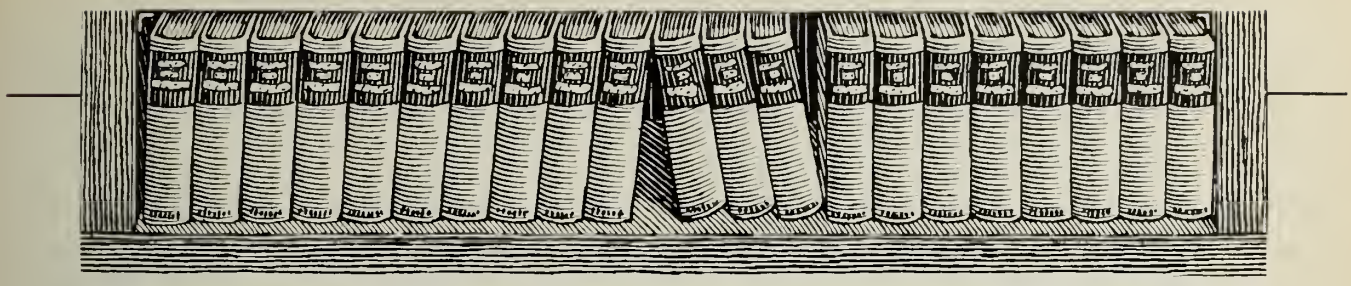
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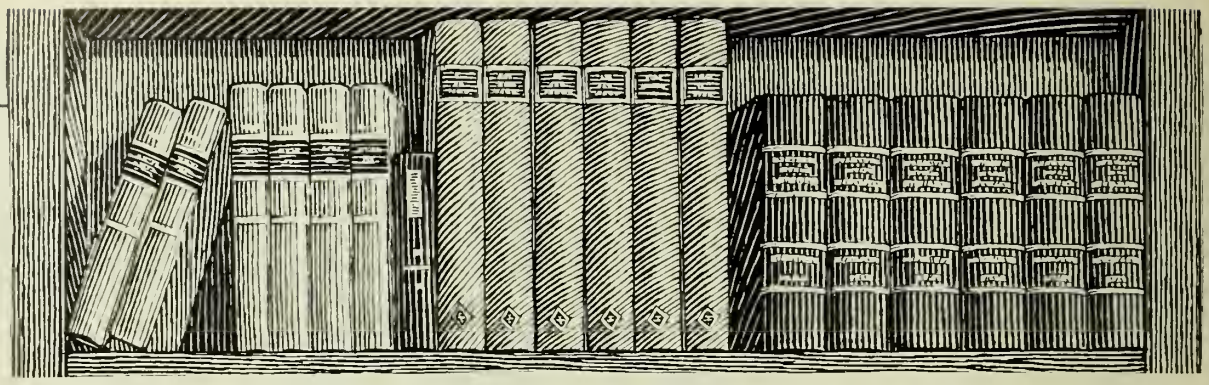
Tapping into the Medical "Information Explosion": Easier Than You Think

By N.J. Wolfe, MSLS and Elizabeth J. Sawyers, MLS

Man's attempts to bring medical literature under control had their origins in the 1870s when Dr. John Shaw Billings, a former surgeon in the Civil War, began an index to medical periodicals received by the office of the Surgeon General of the U.S. Army. Over the years, the publication underwent changes in both format and title and eventually became today's *Index Medicus.* Dr. Billings, a graduate of Miami University and the Ohio Medical College at Cincinnati, most likely never realized his early work would eventually become the primary bibliographic authority for medical literature in the United States.

The term "information explosion" has been coined to explain the rapid pace of publishing activity throughout the world. Available evidence indicates that for more than a century literature has been doubling in size every 25 years. This growth is due to an increase in the number of pages being printed in existing titles, as well as to an increase in the number of titles being published. These new scholarly journals are being created at a rate of 3.9% a year, with an additional 2% ceasing each year, leaving a net growth of 1.9%. Studies of scientific and technical journals, however, have indicated their net growth rate to be closer to 2.2%. Interestingly enough, the number of scientists grows at approximately the same rate, so that the number of journals per scientist remains quite steady.

Coping with the volume of medical literature and keeping up with new developments in health care presents a formidable challenge to the busy practicing physician. Without access to adequate medical information resources, this task could be most difficult or perhaps impossible. Fortunately, the National Library of Medicine's Regional Medical Library (RML) Network makes the nation's medical information resources equally available to all health professionals wherever they may be located. This network was established by NLM in 1965 to ensure that health professionals had equal access to information, whether they were located in a large metropolitan area or in a remote rural location far from a major city. The network is hierarchically structured, with the country divided into seven geographical regions. Each of these regions has a single library that administers and coordinates regional activities, plus a number of other resource libraries, each of



which is responsible for a defined geographical subset of the entire region. The state of Ohio is included within the Greater Midwest Regional Medical Network, which includes the states of North Dakota, South Dakota, Minnesota, Iowa, Wisconsin, Illinois, Indiana, Michigan, Ohio, and Kentucky. Approximately 25 resource libraries and several hundred hospital libraries comprise the network in this region. The normal entry point into the network is the local hospital library.

In addition to the information access provided by the RML Network, a number of technological advances have made the task of identifying and acquiring information much faster and easier, as indicated by the following:

- — User friendly search systems allow health professionals to search databases directly.
- — The full text of a number of major books and journals in the health field are stored in electronic databases and can be accessed directly and printed out as needed.
- — Personal reprint and data management files can be developed by downloading citations from bibliographic databases into a personal computer.
- — Copies of needed journal articles, etc. can be sent from one library to another using telefacsimile.
- — Databases such as MEDLINE can be acquired on compact disk and be available for unlimited search access at no additional cost for connect time or data transmission.

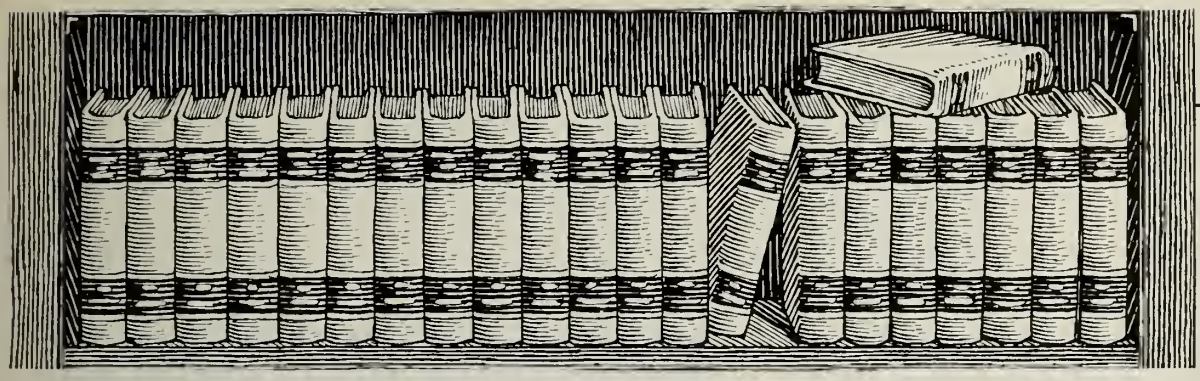
The libraries which make up the RML Network have taken advantage of these technological advances, in order to improve the dissemination of information to physicians and other health professionals. Of most direct and immediate benefit to all health professionals in Ohio is the use of telefacsimile. Each of the seven medical school libraries in Ohio is equipped with a telefacsimile machine, allowing nearly instantaneous transmission of information among those libraries, as well as other libraries throughout the country that have similar equipment.

Within the Regional Medical Library Network, The Ohio State University Health Sciences Library serves as a resource library, as do the other six medical schools in the state. Each of the libraries has responsibility for serving as a backup to the hospital libraries within the surrounding geographic area — providing information from its own collections where possible, or forwarding the request on to an alternate source for completion if not available.

In its capacity as a resource library within the RML Network, the Health Sciences Library at Ohio State draws upon its collection and staff resources to meet the information needs of the health professionals in the Central Ohio area for which it has responsibility. The library and its two branches collect extensively in the subject areas of medicine, nursing, dentistry, optometry, allied medical professions, developmental disabilities, and cancer in support of the academic and service units included in the health complex. There is a continuing effort to select and acquire new materials covering the latest developments in the clinical and research literature for our areas of subject coverage.

At the present time, the OSU Health Sciences Library collection numbers nearly 170,000 volumes, and the library currently receives more than 2,200 journals published both here and abroad. The resources are thus much greater than those found in a typical hospital library, and they are available to anyone who taps into the RML Network. In addition to the books and journals that would be found in a hospital library, the OSU Health Sciences Library also contains a large number of reference sources which can be of great assistance in finding needed information. There is an extensive collection of directories, dictionaries, and statistical resources, as well as numerous printed indexes and abstracts of the biomedical literature, including such titles as *Index Medicus, Hospital Literature Index, Family Literature Index,* or *Sports Medicine.* In addition, theses and dissertations from the schools within the University's health complex are collected, and there is a modest historical collection which contains items dating as far back as the 17th century.

The OSU Health Sciences Library has two features that



distinguish it from similar libraries throughout the country — one is an automated book storage device and the second is a campus-wide online catalog and circulation system. The automated bookstack is a particularly efficient means of storing a large volume of books and journals in much less space than would be needed for standard shelving. This device is used only for storage of older materials; newer materials published within the most recent 10 years are housed outside the machine on open shelving for direct use by library patrons. Materials housed within the automated bookstack cannot be accessed directly, but must be retrieved by library staff on duty at the circulation desk.

The online catalog and circulation system called LCS (Library Control System) contains information about all the titles held by not only this library, but by the entire University Libraries' System with collections in more than 20 locations on campus. As a further aid, the collections of the Center for Research Libraries in Chicago and the State Library of Ohio are also included in the database. This resource not only identifies the titles and volumes owned by the participating libraries, but also indicates when they have been borrowed by someone and are not currently available. Dial access to this database is available to enable library users to dial in by telephone modem to search directly from their offices, laboratories, or homes.

For health professionals who do not have local information resources conveniently available to them, the Health Sciences Library has implemented a new fee-based information service — Medical and Health Information (MHI) — which offers a full range of research and information services. Through MHI staff, patrons can request computer searches from a wide variety of databases, whether a requester wants to retrieve a few current, relevant items for direct patient care or to do an exhaustive search of the literature for research purposes. The content of the databases varies greatly; some cover only journal articles while others may include other types of publications such as government documents, books, or audiovisual materials; some contain only bibliographic citations, others contain abstracts, and some even contain full text. An experienced search analyst works with requesters to ascertain their specific needs and to select the database(s) most appropriate to their research problem from the more than 300 available from the National Library of Medicine and two additional commercial vendors. Requests are filled in 24 hours, but if information is needed immediately, rush service is available for an additional charge. Individuals living close to Columbus have the additional option of coming personally to the library and searching the current MEDLINE file at no charge on CD-ROM (compact disk/read only memory).

MHI also has a document delivery component which provides a number of options to meet individual needs and time

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The Fordham Health Sciences Library at Wright State University announces the availability of two publications, *Ross A. McFarland Collection in Aerospace Medicine and Human Factors Engineering: 1. Catalog of the Library* and *2. Inventory of the Manuscripts.*

The *Catalog of the Library* contains entries for the 2204 cataloged monographs, corporate technical reports, and reference materials, plus 16 videocassettes. There are also listings of the journal holdings, the more than 3,000 federal technical reports, and subject and name indexes.

The 182-page *Inventory of the Manuscripts* is a file folder listing of the 397 Hollinger boxes or 204 linear feet of materials. Included at the end of the *Inventory* are indexes to McFarland's publications, speeches and photographs in the collection, as well as a general index.

These publications may be purchased singly or as a set. The cost of each, $15.00, includes postage and handling. Only prepaid orders are accepted. Checks should be made payable to: FORDHAM HEALTH SCIENCES LIBRARY. Send to: Special and General Collections Librarian, Fordham Health Sciences Library, Wright State University School of Medicine, P.O. Box 927, Dayton, OH 45401-0927. — *Mary Ann Hoffman, Special and General Collections Librarian, Wright State University.*

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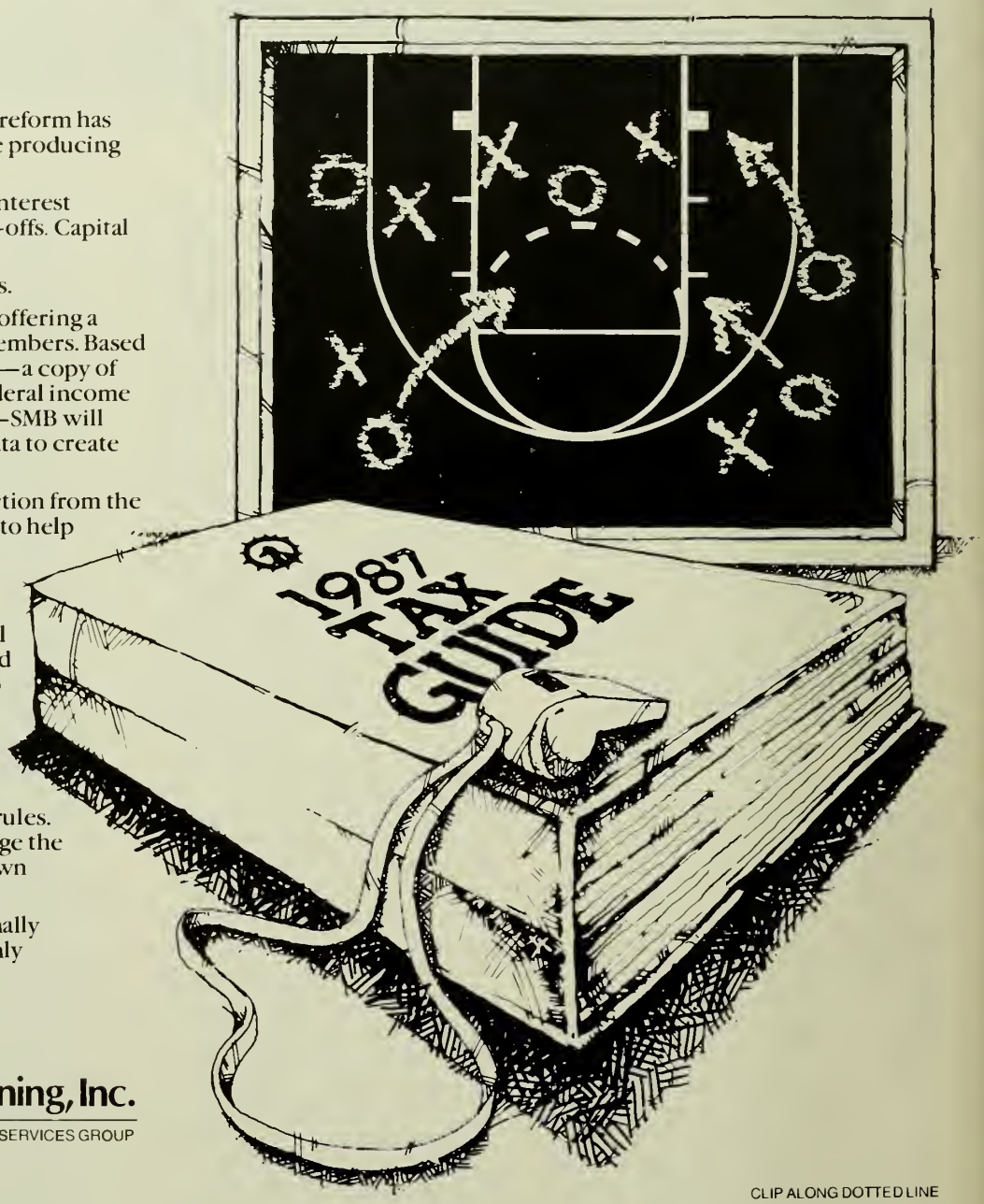
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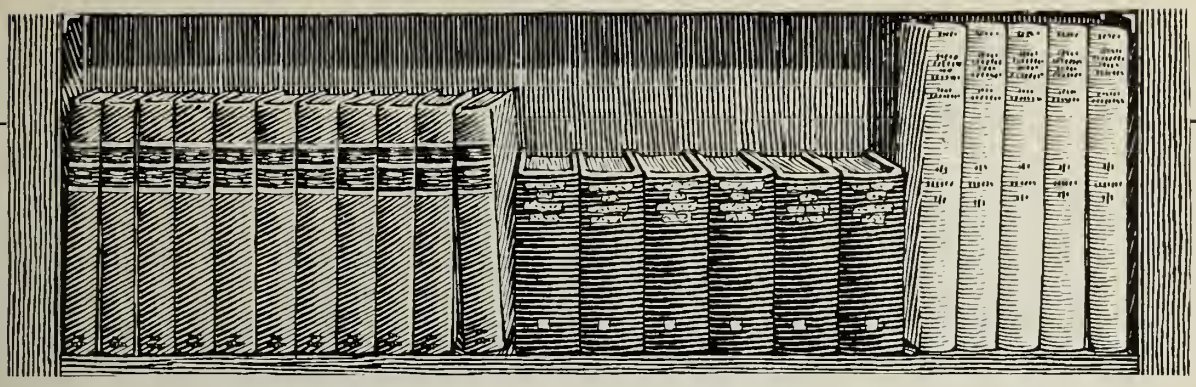
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Whether the need is for a single fact or a comprehensive database search, health care professionals can be assured that biomedical information is just a telephone call away and can be delivered to them promptly — within minutes in emergency situations. For assistance or further information about either the Regional Medical Library Network or this library's fee-based MHI services, please write or call:
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N.J. Wolfe, formerly coordinator of Outreach Services at OSU's Health Sciences Library is now with the Greater Northeast Medical Library Program in New York; Elizabeth J. Sawyers is the Director of the Health Sciences Library at OSU.

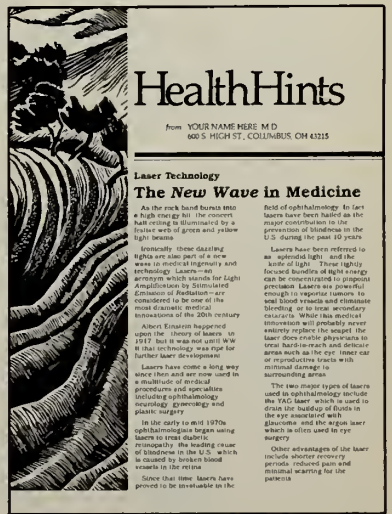
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— *Sara C. Charles, University of Illinois Medical School*

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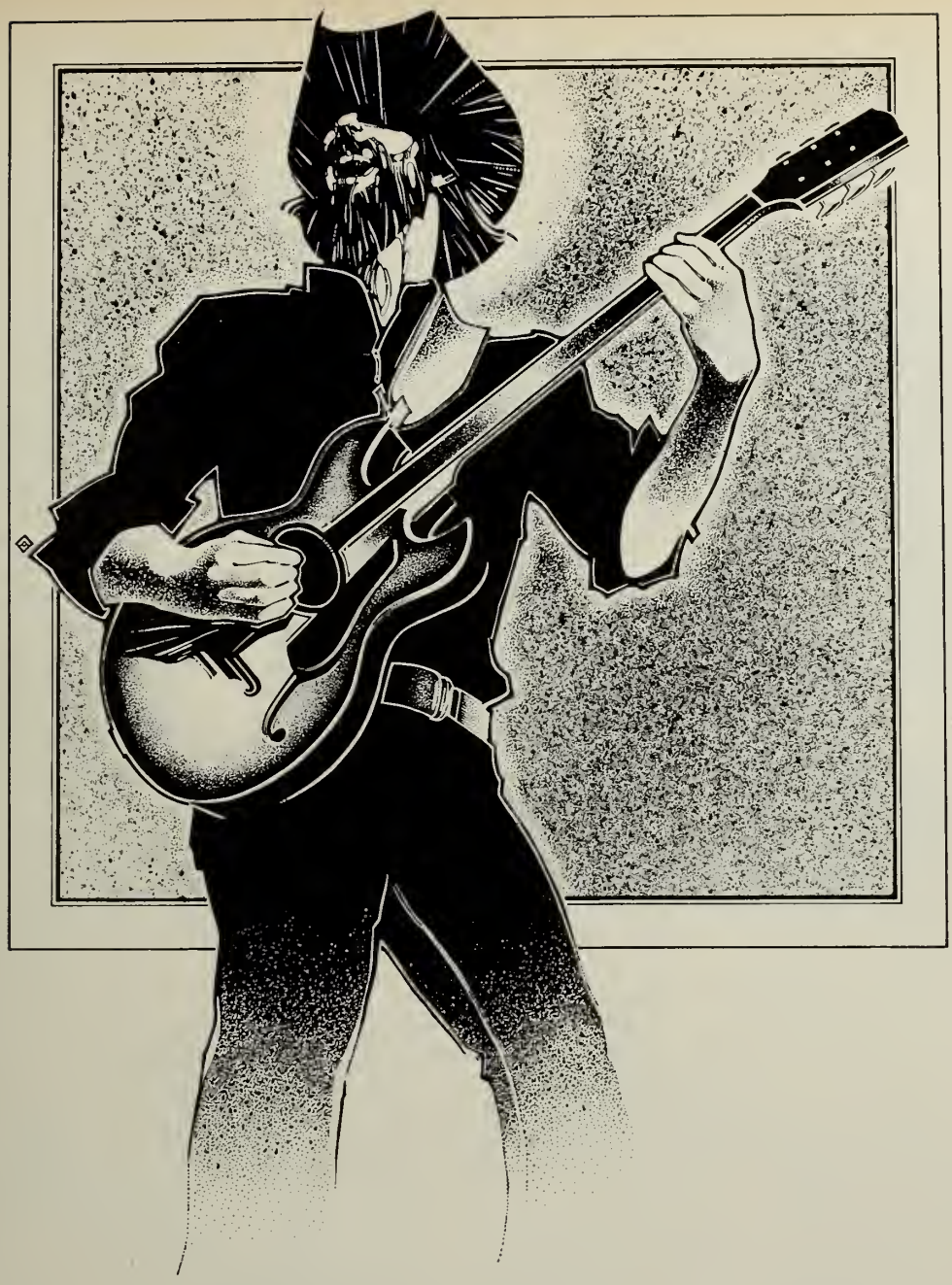
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Knee High in Bluegrass

By Deborah Athy

If you happen to find yourself in Cincinnati — just on the edge of bluegrass country — when the sun is hot, the drinks are cold, and a bluegrass band is revving up for a jamboree, you may recognize Arthur L. Hughes, MD, onstage.

Bluegrass music — the banjo plucking, foot stomping, fiddle strumming variety — is an outgrowth of traditional Appalachian string band music, says Dr. Hughes, a full-time neurologist and part-time mandolin player in the Queen City area.

Back in the '60s in Baltimore, when Dr. Hughes was attending medical school, there was a lot of Appalachian music floating around. It was around this time that he became infatuated with bluegrass and joined a band.

The mandolin, an eight-stringed instrument resembling a small guitar, attracted his attention; partly, he says, because his favorite bluegrass musician, Bill Monroe, played the mandolin.

Monroe, whose recordings include "Knee High in Blue Grass," was the leader of the first

"Playing bluegrass is the best thing in the world. It's a great way to clear the mind. I can't think of anything more relaxing."

bluegrass orchestra. He is "famous as far as bluegrass musicians go," Dr. Hughes says, adding that at age 75, Monroe is still playing.

In 1975, after graduating from medical school, Dr. Hughes ventured to the lulling hills of Cincinnati. "One of the reasons, although not the only reason, I came to Cincinnati is because there are a lot of bluegrass musicians and people who know and support the music." In addition to setting up a medical practice, Dr. Hughes also kept his eye out for a bluegrass band to join.

While bluegrass can't boast the followings that other musical genres can — jazz or rock and roll, for example — Dr. Hughes says there are enough diehard fans that "I don't foresee that it (bluegrass) will be disappearing." In general, he adds, "Ohio is fertile ground" for bluegrass festivals and bluegrass fans.

Currently Dr. Hughes shares his enthusiasm for bluegrass with four members of a band called "Back Up and Push." The band affectionately borrowed their name from an old fiddle tune by the same name. The other sounds in the band include a fiddle, banjo, guitar and bass.

While the band is presently "between gigs," the musicians previously played on a regular basis in a Cincinnati tavern. One of their more recent engagements was getting things hopping at the St. Francis-St. George's medical staff square dance in Cincinnati.

Back Up and Push also has their sound out on vinyl. In addition to a healthy dose of bluegrass, the name of the band's album, "The Bluegrass Prescription," also echoes a little of Dr. Hughes's "other" profession.

The Queen City band performs originals as well as many traditional bluegrass numbers — old-time country music, fiddle tunes, standard bluegrass ditties. Some of the more easily recognizable tunes they strum include "Rocky Top," "Orange Blossom Special," and "Blue Moon of Kentucky."

About performing onstage, Dr. Hughes says, "It was fairly nerve-wracking when I first did it semi-professionally, but now it's very enjoyable and exhilarating."

One of the best times, he says, was one night when a fellow from the audience joined the band onstage with a dobro, a guitar that's played with a metal block and sounds similar to a steel lap guitar. The evening turned into a real jam session, and, as Dr. Hughes recalls, it was a good experience.

There have been times when some of Dr. Hughes's patients have wandered into the audience and were a little surprised to see their doctor onstage. "Sometimes they're flabberghasted: 'hey, that's my doctor!' " And while his musical interests may come up in conversation now and again with patients, Dr. Hughes jokes, "I've never gotten a referral because I play bluegrass."

But *how does* Dr. Hughes juggle a 70-hour-per-week neurology practice with his commitment to the band? It's not easy.

Basically, the music is something that's done at night, he says. He tries to practice an hour every night by himself, and the band usually gets together several times a week. Needless to say, this regimen doesn't leave a lot of extra time for other hobbies, like the proverbial golf game. "I don't play golf," he says, "and I haven't seen a TV program in decades."

But missing "The Cosby Show" or "Miami Vice" isn't that great a sacrifice for Dr. Hughes. As he says, while the music does take a lot of time, "playing bluegrass is the best thing in the world. It's a great way to clear the mind. I can't think of anything more relaxing." Strong stuff.

Dr. Hughes says, over the years, he has run across a number of other musically inclined physicians — the band's former banjo player was a radiologist and he also knows of an ophthalmologist who plays the guitar, an OB/GYN physician who plays the banjo, and an emergency room physician who plays the dobro.

Dr. Hughes himself is completely self-taught on the mandolin. "I did not come from a musical family at all," he says. But does a natural inclination toward bluegrass run in his children? Well, his 15-year-old son *does* play electric bass in a rock band. . . .

Present plans for his band are short and sweet: to continue to

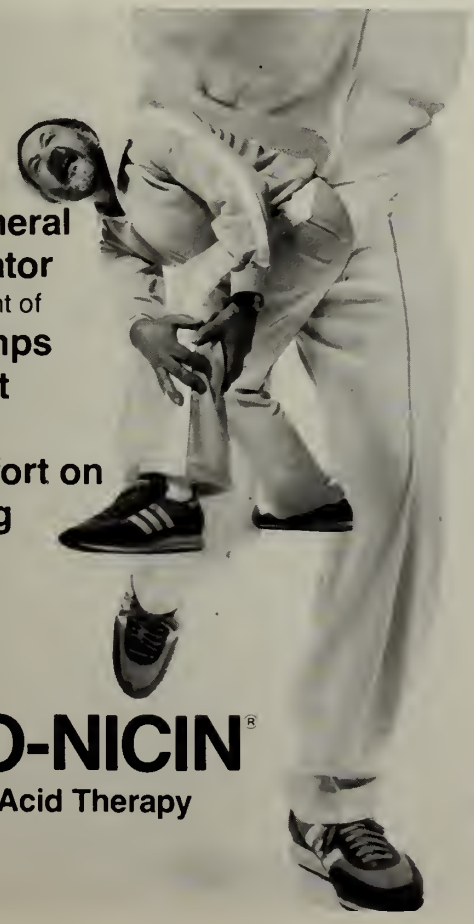
improve and play around town. And, of course, the overall goal is to have fun. "That's why we do it, really — to have fun and to play to the best of our ability." The band is also interested in taking part in a bluegrass festival this summer — something they haven't yet had a chance to do.

While the present situation suits him fine, Dr. Hughes admits, "I've got nothing against being famous. But that drive for the limelight demands more time — for going on the road, practicing, etc. — than he has available. "I couldn't do it and maintain my medical practice, so I don't foresee that happening."

So, by day, Dr. Hughes will practice neurology. And, by night, in his home not far from "the blue moon of Kentucky," he'll be practicing old bluegrass favorites on the mandolin. **OSMA**



"Back Up and Push" is the name of the bluegrass band which features Arthur L. Hughes, MD, on mandolin (second from right).



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The Physician and the Hopelessly Ill Patient

By Society for the Right to Die, 92 pp. $5.00. New York, Society for the Right to Die, 1985.

As stated in the introduction, this small book "is an attempt to clear away many of the uncertainties and misunderstandings" that surround decision making in the management of the hopelessly ill. In general, these objectives are met as well as can be expected when considered in the light of the immense complexity of the problem. The book consists of three sections plus an appendix. The first section is a reproduction of an article appearing in the *New England Journal of Medicine,* April 12, 1984. This was co-authored by ten distinguished physicians. The responsibilities of the patient, the physician and family are defined in a clear, sympathetic, and at the same time, unemotional manner. The importance of communication between all concerned persons, as well as documentation of such communication is stressed.

Several levels of care are recognized and defined: "(1) emergency resuscitation; (2) intensive care and advanced life support; (3) general medical care, including antibiotics, drugs, surgery, cancer chemotherapy, and artificial hydration and nutrition; and (4) general nursing care and efforts to make the patient comfortable, including pain relief and hydration and nutrition as dictated by the patient's thirst and hunger." These care levels are applied in the manner that an informed and competent patient has expressed a desire that they be applied.

The incompetent patient presents a variable and more complicated problem. Good guidelines for managing these difficult situations are presented.

Section two deals directly with commonly asked questions. A question is asked and a concise answer is given. The question and answer format lends itself well to the management of material of this nature.

Section three is a state-by-state summary of living will legislation and case law. This acts as a ready reference, easily used to find the status of such material in any particular state.

The appendix includes very useful examples of a living will as well as guidelines to "do not resuscitate" orders.

This is an excellent book. It is well written and well organized. A great deal of material is covered in minimal space. Documentation is extensive and suitable bibliography is supplied. The book is instructive and would be found very helpful by any person who is involved in any way with severely ill or injured persons. I believe that it would be particulary valuable to the new physician who is dealing with the hopelessly ill for perhaps a first time.

The book has much to commend and little that can be criticized. It does not address the problem of the newborn, infant, or minor. Some of the subject material could perhaps be dealt with in more depth. Periodic revision will be necessary as the pertinent legislation is changing and expanding. In addition, each new medical advance will present a new problem. Harvesting of organs for transplantation is not addressed in this book, but I believe it would be appropriate to add such, as organ harvesting is intimately tied to the terminal care of the hopelessly ill patient. — *John C. Elder, MD, University Heights, Ohio.*

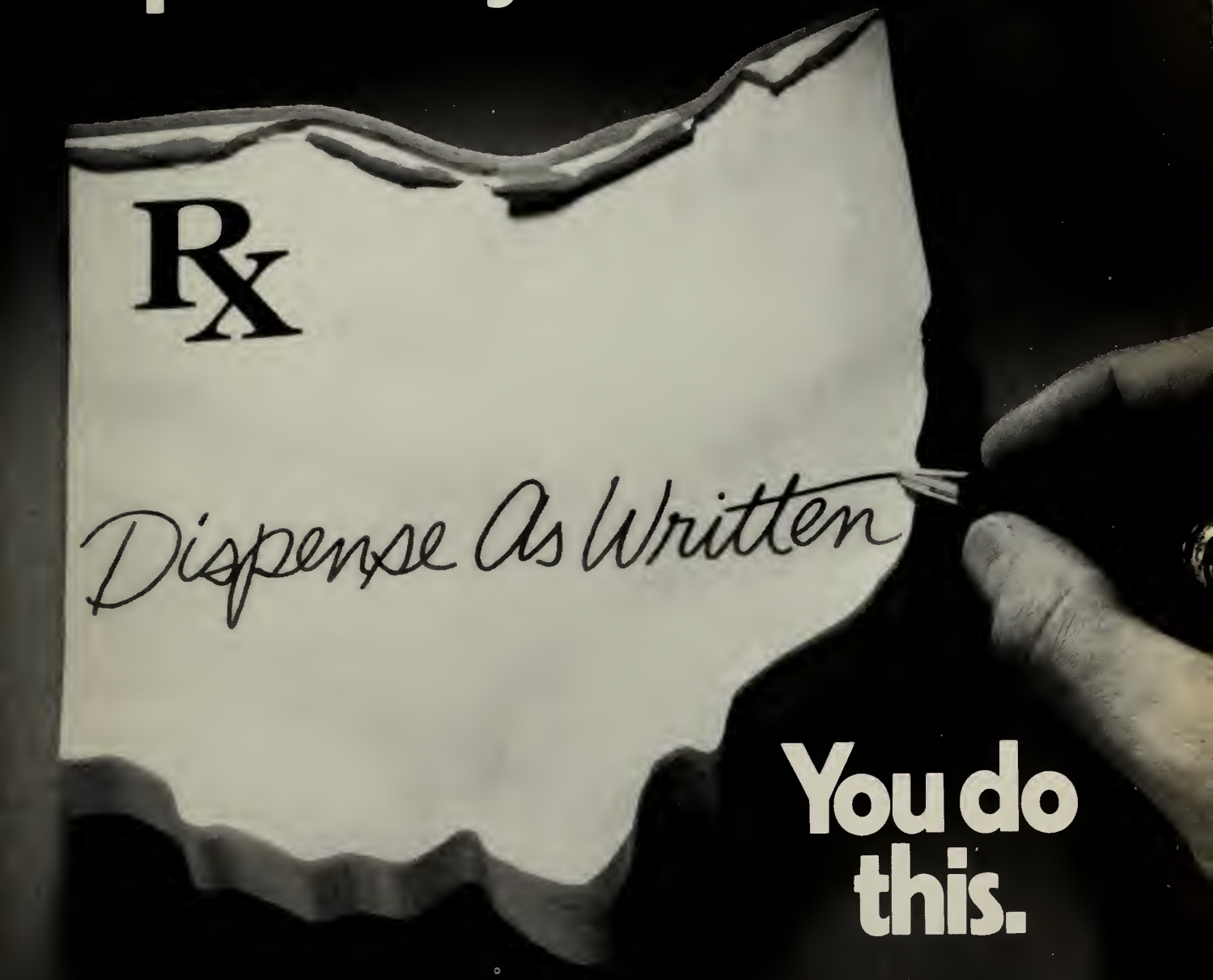
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Please see adjacent page for a summary of product information.

LIBRIUM® Ⓥ
chlordiazepoxide HCl/Roche
5-mg, 10-mg, 25-mg capsules
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders; short-term relief of anxiety symptoms, acute alcohol withdrawal symptoms, preoperative apprehension and anxiety. Usually not required for anxiety or tension associated with stress of everyday life. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.
Contraindications: Known hypersensitivity to the drug.
Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage.
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety disorders and symptoms, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)
Supplied: Librium® (chlordiazepoxide HCl/Roche) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in boxes of 4 reverse-numbered cards of 25, and in boxes containing 10 strips of 10. Libritabs® (chlordiazepoxide/Roche) *Tablets*, 5 mg and 10 mg—bottles of 100 and 500; 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable. P1. 0286

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Do's and Don'ts of Malpractice Prevention . . . *continued*

professional liability company will select and hire an attorney for you.

DO NOT discuss the case with family, friends or colleagues. Comments like, "Maybe I should have done things differently," or "Maybe I made a mistake," may come back to haunt you when your case comes to trial.

DO NOT alter any records or attempt to fill gaps in your records.

DO NOT destroy records associated with the case which you feel may be used against you. Remember Watergate? "Lost" or "incomplete" records can look just as bad as altered ones.

DO NOT fabricate or attempt to reconstruct what you should or could have done in caring for the patient. If you don't remember the exact steps you took in caring for the patient, say so.

DO NOT attempt to communicate with the patient — to apologize, to reprimand or to tell your side of the story — once litigation has begun.

DO NOT openly criticize or talk in a derogatory or negative way about the patient who is suing you — either in private or during testimony. This may be construed to mean that you don't like the patient, and therefore did not give that patient adequate or appropriate care.

DO NOT continue to treat or look upon the individual who is suing you as your patient. In bringing legal action against you, he or she has terminated the doctor/patient relationship, and you are no longer his or her advocate.

DO NOT volunteer additional information or give lengthy explanations when asked specific questions during testimony. Limit your responses only to the question at hand, and allow your attorney time to cue you as to the appropriateness of the question before you answer.

DO NOT openly disagree with or challenge your defense attorney during depositions, arbitration or trial. If you are unhappy with the way he or she is handling the case, wait until you can discuss the matter in private.

DO NOT take the accusations leveled against you personally. The patient and his or her attorney will try to prove that you have been negligent, incompetent, etc., and will attack you and your credentials and performance as a physician in order to prove their case. Ignore these, realizing it is simply a part of the process.

DO NOT harass your attorney or your insurance company for quick and easy results. The legal process is a long and complicated one — taking up time with criticisms and complaints will only make it longer. — *Susan Porter*

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The OSMA offers classified advertising under headings designed to serve OSMA members and the medical community. Categories generally available are: employment opportunities, equipment for sale, medical office space for sale or lease, medical practices for sale, positions wanted, services and CME seminars.

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$1.50 per word for regular ads with bold title, $1.75 per word for ads appearing in a box. Payment for the ad must accompany advertising request. Ads must be typed. Closing date for classified ads is first day of month preceding publication.

The OSMA Journal reserves the right to refuse or delete classified ads without explanation and to refer advertisements of a commercial nature to the display advertising department, at the publisher's discretion.

Send classified ads to:

Ohio Medicine
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Attention: Classified Ad Manager

Telephone orders for classified ads are not accepted.

Need a partner? Selling a practice? Looking for office space or a piece of equipment?

Next month, place a classified ad in OHIO MEDICINE . . .

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Employment Opportunities

ASSOCIATE RESIDENCY PROGRAM DIRECTOR

The Northeastern Ohio Universities Colleges of Medicine (NEOUCOM) Psychiatry Residency Training Program seeks a board certified psychiatrist to assume a major leadership role as an Associate Residency Program Director at Akron General Medical Center (AGMC). AGMC is a 507-bed community hospital with a major teaching affiliation with NEOUCOM. The hospital has two units comprised of 58 adult psychiatric beds and an outpatient service.

Major duties will include teaching residents involved in adult inpatient and outpatient activities.

Salary is competitive, with an opportunity for private practice, research and teaching of undergraduate medical students. EOE/AAE Direct inquiries to Moshe Torem, MD, Akron General Medical Center, 400 Wabash Avenue, Akron, Ohio 44307.

BOARD CERTIFIED INTERNIST FACP critical care seeks group practice or to buy retiring physician practice. Send reply to: C. Singh Thethi, MD, FACP, 1410 Marlin Drive, Marion, IN 46952.

CINCINNATI: GENERAL PRACTITIONER. Busy, well-established two person general practice seeks competent g.p. to fill vacancy of retiring doctor. Contact: Physician Relations Department, Good Samaritan Hospital, 3217 Clifton Avenue, Cincinnati, OH 45220, (513) 872-1278 or (513) 872-1453.

CINCINNATI: INTERNIST. Busy internal medicine practice with strong geriatric base seeks well-qualified internist for immediate opening. Contact: Physician Relations Department, Good Samaritan Hospital, 3217 Clifton Avenue, Cincinnati, OH 45220, (513) 872-1278, (513) 872-1453.

EMERGENCY MEDICINE: Emergency Medicine group has immediate opening for residency-trained, board certified/prepared physician for two hospital emergency medicine practices. Base hospital is Good Samaritan, a 688-bed private teaching hospital with trauma service. Excellent salary and seven weeks vacation. Send CV to Marshall H. Odom, MD, 3412 N. Clubcrest Avenue, Cincinnati, OH 45209 or call at (513) 872-2536.

EVANSVILLE, INDIANA — Immediate position available for board certified Family Practitioner in busy, growing network of ambulatory care centers. Excellent income. Flexible scheduling. Contact MED Medical Centers, 3844 First Ave., Evansville, IN 47710. ATTN: Rebecca Parker.

FAMILY PRACTICE — Board or Board Eligible practice opportunity for one or two physicians. Excellent Akron area hospitals. Call 216-253-1329.

FAMILY PRACTICE — Boarded or Board Eligible — Work with three other certified Family Physicians in modern facilities. Excellent contract offered. Please send CV or call for more information. William Plassman, Administrator, Community Memorial Hospital, 208 North Columbus Street, Hicksville, OH 43526. (419) 542-6552.

FAMILY PRACTICE — Excellent opportunity for hospital practice in beautiful, historic Marietta, Ohio, or neighboring rural communities. Attractive package. Send CV to: 401 Mathews Street, Marietta, OH 45750 or call for information. Rick Cochran (614) 374-1791.

FAMILY PRACTICE: Opportunity to join group practice 40 miles outside Columbus. Board eligibility required. $75,000 plus malpractice. Opportunity for seniority in 3-4 years due to retirement of partners. Call Pat Purcell (518) 286-6600, or send CV to Hospital Recruiters, PO Box 31, East Greenbush, NY 12061-9990.

FAMILY PRACTICE/INTERNAL MEDICINE — Physician wanted to join busy, established family practitioner. Excellent practice facility for acute and continual primary care. All administrative and practice expense furnished. No capital investment required. Base salary with productivity bonus and compensation package. Excellent income potential. Hospital and excellent school system with community college, two major lakes and recreation areas. Rural community with small industries, less than one hour from three metropolitan areas. Send CV — Davis S. Ayres, MD, 1400 North High Street, Hillsboro, OH 45133.

FAMILY PRACTICE OPPORTUNITY. Thriving Family Practice in Ravenna, Ohio is available immediately. Ravenna is in northeast Ohio, Portage County seat, population 12,000; however, the practice draws from the entire county of 130,000. Superb community hospital of 286 beds with almost all specialties available. Present practitioner leaving to assume medical directorship of the hospital and will be available to introduce. Desire FP with Boards or soon to take them. Terms negotiable. Write to: David S. Palmstrom, MD, 250 South Chestnut Street, Ravenna, Ohio 44266, or phone 216-296-9606.

FAMILY PRACTICE PHYSICIAN BE/BC WANTED — Senior member of well managed two physician family practice corporation retiring August 1. Well established practice in south suburban Dayton, Ohio. Better-than-competitive salary, benefits, and profit sharing. Partnership opportunity. Ten physician co-op for night/weekend call. Satellite hospital 1.5 and teaching parent hospital 7 miles from office. Full specialty backup. No obstetrics. On site laboratory and x-ray. Outstanding cultural, educational, and recreational opportunities including those in nearby Cincinnati with major league sports. Contact Verne H. Dodson, MD, 1012 East Central Ave., Miamisburg, Ohio 45342. Phone: 513-866-1012.

HEALTH CARE PERSONNEL CONSULTING, INC., A DIVISION OF THE HEALTH CARE GROUP, specializes in valuation and sales. We have practices currently available in the following specialty areas: **Allergy, Dermatology, Family Practice, Internal Medicine, Ophthalmology, Pediatrics, Psychiatry, Psychology, Radiology and Urgent Care.** For more information regarding selling or buying a medical practice, contact our brokerage divi-

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sion at The Health Care Group, 400 GSB Bldg., Bala Cynwyd, PA 19004 or call (215) 667-8630.

HOUSE PHYSICIAN — Full time Medical/Surgical House Physician position available immediately. Ohio license is required. Prefer Board eligible/certified physician. Hospital is in a community setting. Attractive salary and benefits. Contact Parma Community General Hospital, c/o Medical Staff Services, 7007 Powers Blvd., Parma, OH 44129.

IMMEDIATE POSITION AVAILABLE. Multispecialty Northeastern Ohio Group seeking BC/BE primary care physicians: Family Practice, Internal Medicine, Pediatrics and OB/GYN. Guaranteed salary with opportunity for ownership. Excellent Benefits. Reply Box 133, c/o Ohio Medicine, 600 South High Street, Columbus, OH 43215.

INTERNIST with an interest in Gastroenterology needed to join a Cardiologist/Internist in a rural Louisiana town from July, 1987. Attractive first year salary, benefits, and early partnership. If interested, send CV to: Manzoor H. Qazi, MD, 1101A Port Arthur Terrace, Leesville, LA 71446.

MARIETTA, OHIO — Emergency Department directorship and staff position available at 200-bed facility. Board certification or Board eligibility in Emergency Medicine or primary specialty preferred. Contact: Emergency Consultants, Inc., 2240 S. Airport Rd., Traverse City, MI 49684; or call 1-800-253-1795, in Michigan 1-800-632-3496.

NORTHWEST, OHIO — full time position available in medical/industrial clinic. Excellent salary plus benefits. Reply to Box 134, c/o Ohio Medicine, 600 South High Street, Columbus, OH 43215.

OHIO: Emergency Medicine positions ranging from part-time placements to full-time directorships. Low to high volume hospitals throughout the state. Guaranteed hourly rate plus malpractice insurance. Contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 26, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

OHIO: Full-time emergency department opportunities are currently available at our client hospital in western Ohio. Progressive medical community, less than a two-hour drive from Toledo, Dayton, or Columbus. Excellent facility with high volume ED. Reimbursement in excess of $120,000, plus occurrence malpractice insurance coverage, CME allowance, reimbursement of professional dues. For more details on this opportunity or other opportunities in Ohio, contact Sheila Bodenschatz, Spectrum Emergency Care, PO Box 27352, St. Louis, MO 63141; 1-800-325-3982; (314) 878-2280.

OHIO, NORTHEAST/CLEVELAND: Staff position for Board Certified/prepared in emergency medicine or other primary care specialties for ED, 8000-32000 patient visits per year. Exc. compensation & benefit pkg: pd. health, life, disability, and dental ins; pension and PS plan; educ. stipend; and vac. Professional liability coverage paid by corp. Advancement to shareholder level for well-qualified individual. Please send CV to PO Box 2600, Lakewood, Ohio 44107.

OPPORTUNITY AVAILABLE to physician in our community. Firelands Community Hospital is a new 273-bed facility located midway between Toledo and Cleveland on Lake Erie. Primary service area populations is 80,000.* Send CV to 1101 Decatur St., Sandusky, OH 44870 or call (419) 626-7721. (*All support services available.)

URGENTLY NEEDED

GENERAL INTERNIST or experienced **FAMILY PHYSICIAN** to take over Active General Practice due to the sudden death of a local physician.

Fully equipped office with active patient records located in Loudonville, Ohio in beautiful Mohican country. The office is located next to the Loudonville Kettering Hospital, a 23-bed Acute Care Hospital with O.R., E.R. and CCU — no O.B. This is an excellent opportunity for a physician wishing to be independent and raise his family in a rural setting with good schools and cultural activities. The area is still free of contractural plans and has a very low unemployment rate.

Out-of-door activities available locally include hunting, fishing, boating, camping, water and snow skiing.

For more details call
Mrs. Mary Ellen McMullen (419) 994-3552
J.H. Cooperrider, M.D.,
Chief of Staff (419) 994-4651

PACIFIC NORTHWEST. Practice opportunities with the Wenatchee Valley Clinic. Situated on the Columbia River in the foothills of the Cascade Mountains, the Wenatchee Valley Clinic is a multispecialty medical group of 105 physicians with seven satellite locations. Currently we are seeking the following physicians to join our main facility in Wenatchee: Pediatrician, Allergist, Nephrologist, General Internist, and Psychiatrist. Excellent compensation and benefit packages are available. Wenatchee provides a high quality of life for those interested in an abundance of recreational opportunities in a family-oriented rural setting. If interested, send your CV to Dr. Gerald Gibbons, Medical Director, Wenatchee Valley Clinic, 820 N. Chelan Ave., Wenatchee, Washington, 98801, or call 509/663-8711, ext. 205.

PHYSICIAN

Group Health Associates is searching for that particular physician interested in working full-time (40 hours per week) in our Clifton Urgent Care Department. We have an excellent compensation package and good support services. This position requires no hospital responsibilities or continuing patient care. Please send your C.V. to Search Committee, Group Health Associates, 2915 Clifton Avenue, Cincinnati, OH 45220.

PHYSICIAN ADMINISTRATOR — The Industrial Commission of Ohio is seeking a qualified individual for the position of medical director/asst. admin. rehab. services for the W.O. Walker Rehabilitation Center in Cleveland, Ohio, which is scheduled to open in the fall of 1987. Ultramodern facility. State-of-the-art equipment. Located in University Circle. Excellent salary with comprehensive benefit package. Applicants must be board certified with a specialty area of physiatrist, orthopedist or surgeon with rehabilitation experience. Knowledge of worker's compensation and occupational medicine is helpful. Devote your professional skills and time to a program designed to assist ambulatory patients who have sustained an occupational injury or illness. Avoid DRGs, mandatory assignment and malpractice premiums. Send resume and salary history to Industrial Commission of Ohio, Director of Human Resources, 78 E. Chestnut, Columbus, OH 43266. 614-462-6491 EEO/M/F/H.

PHYSICIAN OPPORTUNITIES — SOUTHWEST — We have unadvertised solo, group and hospital-based opportunities for general practice and most specialties. Financial guarantees, benefit packages negotiable. Fee paid. Professionals serving professionals. Send CV to FRH Associates, 3942 Newhall Rd., Columbus, OH 43220 or call 614/451-4372.

PSYCHIATRIST — Full-time position. Must be licensed in Ohio. Board eligible or board certified in Psychiatry. Approved three-year psychiatric residency. Starting salary range: $57,034-$66,019 based on qualifications. Civil service employment. Full benefit package. Equal opportunity employer. Send resume to: Ann Henry, Personal Director, Oakwood Forensic Center, 3200 North West Street, Lima, Ohio 45801.

PSYCHIATRISTS — Dayton Mental Health Center, Wright State University Affiliate, has full-time and part-time positions available for Psychiatrists. Acute and extended care for approximately 304 adult and geriatric patients. These positions may include the teaching of medical students and psychiatric residents. Board certified or eligible for Ohio medical license required. Salary commensurate with experience plus fringe benefits. Send CV and references to Wayne R. Anable, DO, Medical Director, 2611 Wayne Avenue, Dayton, OH 45420.

PSYCHIATRIC PHYSICIAN — Full-time position. Must be licensed in Ohio. Requires two years approved residency training in psychiatry or five years experience in psychiatric setting under supervision or board eligible or certified psychiatrist. Starting salary: $42,952. Civil service employment. Full benefit package. Equal opportunity employer. Send resume to: Ann Henry, Personnel Director, Oakwood Forensic Center, 3200 North West Street, Lima, OH 45801.

PROGRESSIVE 325-BED acute care community hospital in the Midwest is seeking a Board certified pathologist to join existing group. Strong background in anatomical pathology with special interest in oncology required. Competitive compensation and benefits package. Please reply to Ohio Medicine, Box, 132, 600 South High Street, Columbus, OH 43215.

RADIOLOGIST for a busy diagnostic center. General radiology and ultrasound experience in northeast Ohio. Salary negotiable. Reply 361 East Waterloo Road, Akron, Ohio 44319.

STAFF PSYCHIATRISTS — Immediate openings available for Board Certified/Board Eligible psychiatrists, full and/or part-time in 131-bed acute state run psychiatric hospital, located in Cuyahoga Falls, Ohio. Teaching opportunity/faculty appointment for potential candidate available through Northeastern Ohio Universities College of Medicine. Salary negotiable. Send Curriculum Vita or call: Hae Wohn Johng, MD, MPH, Medical Director, 330 Broadway East, Cuyahoga Falls, OH 44221, Phone: (216) 929-8301. *An Equal Opportunity Employer.*

SEEKING INTERNAL MEDICINE Associates for Family Medicine Group in Wilmington, Ohio. Full service facility with laboratory, x-ray and ancillary services. A second internist for cross-coverage may be recruited in one year. Salary guarantee, plus incentive pay, plus benefits. Opportunity for full partnership in one year. Reply to: Wilmington Medical Associates, Inc., 1184 W. Locust St., Wilmington, OH 45177.

SEEKING FAMILY PHYSICIAN to join growing group in Wilmington, Ohio. Full service facility with laboratory, x-ray, and ancillary services. Prefer obstetric partner, but not mandatory. Salary guarantee, plus incentive pay, malpractice and health insurance. Opportunity to become full partner after one year. Position available now. Reply to: Wilmington Medical Associates, Inc., 1184 W. Locust St., Wilmington, OH 45177.

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FOR SALE: ZANESVILLE, OH, Large building presently used as medical complex (9,240 sq. ft.). Wide road frontage on two main thoroughfares. Adjacent to Bethesda Hospital, (352-bed facility). Non-supporting interior walls adjust to requirements. Jane Donoho, Wilfred C. Baker/HER, Realtors, (614) 454-8595.

FOR SALE OR LEASE: Medical office building. Superior location adjacent to Licking County Memorial Hospital. 10,585 square feet with partial basement. GUANCIALE & JOHNSON REAL ESTATE, INC. Dan Guanciale, agent (614) 345-4013.

OFFICE SPACE FOR LEASE — Akron (Fairlawn) Ohio. 2500 square feet. Ideally suited for one or two physicians. Patient reception area, treatment room, six exam rooms, three private offices, lab. Call 216-253-1329.

Position Wanted

POSITION DESIRED. Experienced BE Family Physician, residency trained. Extensive skills in primary care medicine. Presently seeking a regular part-time weekend position in an urgent care setting beginning July, 1987. ACLS, Ohio licensed, location open. Reply to: Ohio Medicine, Box 131, 600 South High Street, Columbus, OH 43215.

Practice for Sale

COLUMBUS, OHIO well-established OB/GYN practice for sale. Terms available. Physician relocating. (614) 863-6804.

ORTHOPEDIC PRACTICE FOR SALE: Southwestern Ohio, population 50,000. Easy access to two metropolitan areas. Sale includes orthopedic facilities (x-ray, etc.). Income may gross over $200,000. Large number of follow-up industrial cases. Please send reply to: Ohio Medicine, Box 130, 600 S. High St., Columbus, OH 43215.

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8. I didn't sign up.
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10. Asthma runs in my family.
11. I forgot to eat this morning.
12. I'm allergic to flowering magnolia."



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COLLEAGUES IN THE NEWS

J. Sheldon Artz, MD, Cleveland, has been elected president of the Northeast Ohio Society of Plastic and Reconstructive Surgeons. Dr. Artz is the co-director of The Center for Plastic Surgery, Inc., and an assistant clinical professor at Case Western Reserve University.

Gilbert Bucholz, DO, has been elected to the board of DOCARE, a volunteer medical organization which offers health care services to needy people in Central America, Mexico and the Caribbeans.

Richard R. Capone, MD, a Lima gastroenterologist, has been named medical chief of staff of St. Rita's Medical Center.

H. William Clatworthy, Jr., MD, Delaware, was honored recently at Columbus' Children's Hospital for his medical accomplishments. Dr. Clatworthy is one of only five pediatric surgeons in the world to receive top honors from both the American Academy of Pediatrics and the British Association of Pediatric Surgeons.

Susan E. Dunkin, MD, Peebles, a family physician at Peebles Family Health Center, and **C. Timothy McKinley, MD,** Mt. Orab, of Sardinia Medical Center, were honored by the Southern State Community College for their professional accomplishments.

Julius Fishman, MD, medical director of the Menorah Park Center for the Aging, has been elected chief of Geriatric Medicine of the Department of Medicine at Mt. Sinai.

David E. Crouch, MD, a Port Clinton family physician, has assumed the presidency of Magruder Hospital's medical staff.

Leonard M. Gaydos, MD, Tiffin, has been named one of Ohio's 1987 Outstanding Team Physicians by the Ohio State Medical Association and the Ohio High School Athletic Association.

George Hawwa, MD, a Garfield Heights internist, has been appointed director of the Community Hospital of Bedford's Department of Medicine.

Leonard Heinz, MD, a Toledo radiologist, has been named chief of staff of the Toledo Hospital medical staff.

Stephen T. House, MD, Dayton, has been named chief of staff of Kettering Medical Center's Sycamore Hospital.

Ronald Irvin, MD, Cincinnati, has been elected president of the Cincinnati Pediatric Society.

Cheryl V. Gray, MD, a Fremont internist, has been named the "Young Career Woman" candidate by the Fremont Business and Professional Women's Club.

Arthur G. James, MD, Columbus, is one of 10 people who was inducted this year into the Horatio Alger Association of Distinguished Americans. The Horatio Alger Association is a non-profit service organization dedicated to recognizing those who have risen from humble beginnings or adverse circumstances to achieve outstanding success. Dr. James, a coal miner's son from eastern Ohio, is professor emeritus of surgery at Ohio State University Hospitals and medical director of the $54 million Cancer Research Institute under construction at OSU.

Donald Jungles, MD, a Cleveland internist, has been named to the Board of Trustees of Laurel Lake, a life-care retirement community in Hudson.

Su-Pa Kang, MD, a Toledo gastroenterologist, has been elected president of the Academy of Medicine of Toledo and Lucas County.

Gary A. Kleinman, MD, an internist from Cleveland, has been elected president of the Marymount Hospital medical staff.

Charles S. Li, MD, a Parma plastic surgeon, has been elected president of the medical staff of Parma Community General Hospital.

Peter Lancione, MD, Bellaire, a member of the Ohio Medical Board, was recently honored for 50 years of service at Bellaire City Hospital.

Praful V. Maroo, MD, Cleveland, has been elected a member-at-large to Lutheran Medical Center's (LMC) Medical Council. Dr. Maroo is the chief of Cardiology and director of the Cardiovascular Lab at LMC.

Gaudencio S. Obail, MD, a Cincinnati internist, has assumed the presidency of the Association of Philippine Physicians of Greater Cincinnati.

Classifieds . . . *continued*

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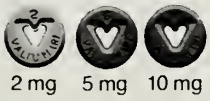
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Clinical Prof. of Occup. Medicine
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Cleveland, OH 44132

Do Not Substitute

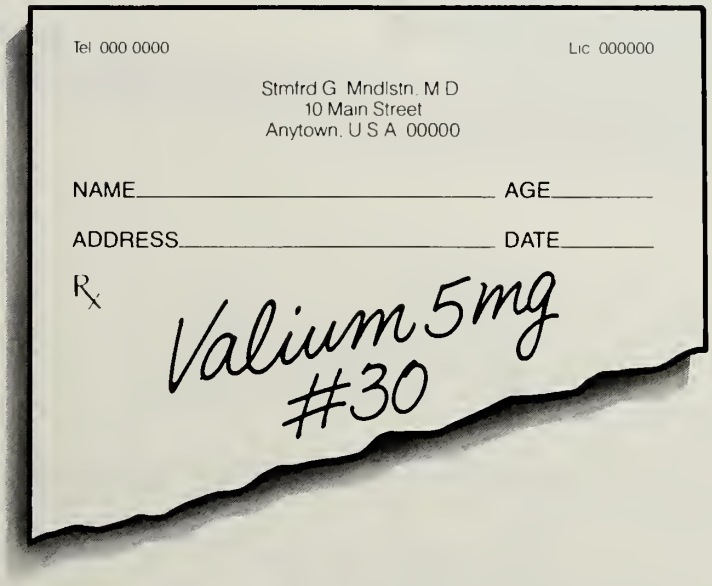
VALIUM® (IV)

brand of diazepam/Roche



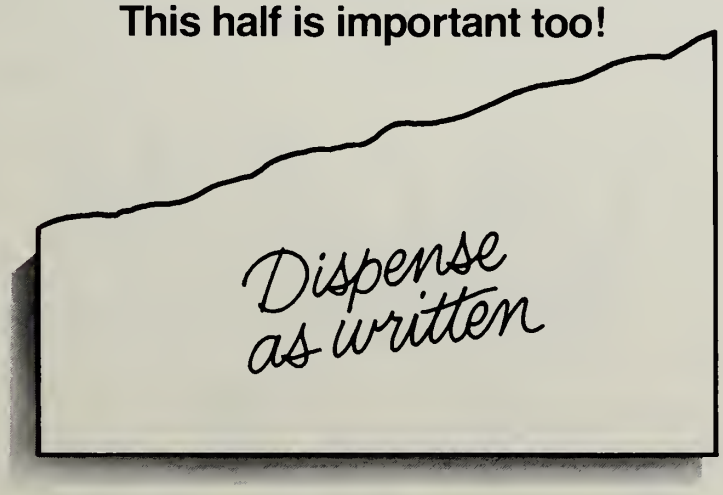
2 mg 5 mg 10 mg

The One You Know Best



Are you writing only half a prescription for it?

This half is important too!



Be sure to write a complete prescription.

Specify "Dispense as written."

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To complete your prescription,
be sure to write
"Dispense as written."
This "flags" both pharmacist and patient
that you want the *brand* to be dispensed.
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